

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9256**

FILED MAR 26 1953

BIRTH NO. _____ REG. DIST. NO. **91** PRIMARY REG. DIST. NO. **5330** Registrar's No. **4**

1. PLACE OF DEATH a. COUNTY Proxford		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY Proxford	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cherryville MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cherryville MO 0280	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) Sarah (First) Louise (Middle) Wolf (Last)			4. DATE OF DEATH March 18 53 (Month) (Day) (Year)		
5. SEX F	6. COLOR OR RACE W	7. MARRIED - NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH April 29-1881	9. AGE (In years last birthday) 72	10. IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or foreign Country) Deer Creek MO	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Tom Gregory		13b. MOTHER'S MAIDEN NAME Julie	
14. NAME OF HUSBAND OR WIFE John Wolf		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Neal Patton		ADDRESS Cherryville Mo			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute debility		10 yrs.	
		DUE TO (c) _____			
		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 491X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **May 1944** to **Mar 12, 1953**, that I last saw the deceased alive on **Mar 12, 1953**, and that death occurred at **8:30 AM**, from the causes and on the date stated above.

23a. SIGNATURE Dr. J. H. Hober	(Degree or title) D.O.	23b. ADDRESS Steelville MO	23c. DATE SIGNED 3/20/53
24a. BURIAL, CREMATION REMOVAL (Specify)	24b. DATE March 19-53	24c. NAME OF CEMETERY OR CREMATORY Matern Cemetery	24d. LOCATION (City, town, or county) (State) Cherryville MO

DATE REC'D BY LOCAL REG. 3/21/53	REGISTRAR'S SIGNATURE Elaine Harrison	78-0	25. FUNERAL DIRECTOR'S SIGNATURE James H. Hober	ADDRESS Steelville MO
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Henry M. Jones
.....
working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed *Henry M. Jones*
.....

Licensed Embalmer No. *27638*

P. O. Address *Stockville, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.