

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9508

State File No. \_\_\_\_\_

FILED APR 14 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 361

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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Roubidoux</u> <u>1070</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St John's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>4 mi East of Plato, Missouri</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>BEULAH</u> b. (Middle) <u>BESSIE</u> c. (Last) <u>WOLFE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 5 1953</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 4, 1895</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James H. Rush</u>	13b. MOTHER'S MAIDEN NAME <u>Rosie Mier</u>	14. NAME OF HUSBAND OR WIFE <u>Oliver Wolfe</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>491-24-3981</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Oliver Wolfe</u>	ADDRESS <u>Plato, Missouri</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANCECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331X</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>Springfield</u> (COUNTY) <u>Greene</u> (STATE) <u>Mo.</u>
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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? _____
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22. I hereby certify that I attended the deceased from Apr 5, 1953 to Apr 5, 1953, that I last saw the deceased alive on Apr 5, 1953, and that death occurred at 4:46A m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____	23b. ADDRESS <u>609 Cherry St.</u>	23c. DATE SIGNED <u>Apr 7 1953</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>April 5, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt Pisgah</u>	24d. LOCATION (City, town, or county) (State) <u>Texas County, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>4-8-53</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Springfield, Mo</u>
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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed James W. Wain  
Licensed Embalmer No. 4650

P. O. Address Springfield, 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.