

FILED MAY 3 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12362

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001 Registrar's No. 16-8

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE TEXAS b. COUNTY GREGG	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) JOPLIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) GLADWATER	
c. LENGTH OF STAY (In this place) 1 MO.		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2215 EMPIRE AVENUE			

3. NAME OF DECEASED (Type or Print) a. (First) WILLARD b. (Middle) LAVERNE c. (Last) WOLFE	4. DATE OF DEATH (Month) (Day) (Year) APR. 22, 1955
5. SEX M	6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 12, 1886
9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days
	IF UNDER 18 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATED RESTAURANT	10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	11. BIRTHPLACE (State or foreign country) DECATUR, ILLINOIS	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME FRANK WOLFE	13b. MOTHER'S MAIDEN NAME KATHRYN BOWLES	14. NAME OF HUSBAND OR WIFE MRS. MYRTLE WOLF
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME CARL RICHEY	ADDRESS 215 S. 5TH, LEAVENWORTH, KANSAS
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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 2 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) _____ II. 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	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) (COUNTY) (STATE)
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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 Mar. 16, 1955, to April 22, 1955, that I last saw the deceased alive on April 22, 1955, and that death occurred at P. m., from the causes and on the date stated above.

23a. SIGNATURE <i>Handwritten Signature</i> (Degree or title) M.D.	23b. ADDRESS 607 Frisco Bldg., Joplin, Mo.	23c. DATE SIGNED 4-25-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-25-55	24c. NAME OF CEMETERY OR CREMATORY OZARK MEMORIAL PARK	24d. LOCATION (City, town, or county) (State) JOPLIN, MISSOURI
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DATE REC'D BY LOCAL REG. 4-27-55	REGISTRAR'S SIGNATURE <i>Handwritten Signature</i> 138-0	25. FUNERAL DIRECTOR'S SIGNATURE STEVE PARKER MORTUARY	ADDRESS JOPLIN, MO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

County Health Office
County File Number
Date Filed
MAY 2 1955

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin 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.