

FILED SEP 28 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29881

State File No. 4021

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

|   |  |   |                                    |
|---|--|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo</b> b. COUNTY <b>Jackson</b> |                                    |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b> |  | c. LENGTH OF STAY (In this place) <b>12 yrs</b>   | c. CITY OR TOWN <b>Kansas City</b> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>144 No. Belmont</b>                                  |  | e. STREET ADDRESS (If rural, give location) <b>144 No. Belmont</b>  |                                    |

|  |                                |   |  |    |  |
|--|--------------------------------|---|--|----|--|
| 3. NAME OF DECEASED (Type or Print)  |                                |   | 4. DATE OF DEATH (Month) (Day) (Year)                              |    |  |
| a. (First) <b>JOHN</b>   | b. (Middle) <b>HENRY HENRY</b> | c. (Last) <b>WOLFE</b>  | 9  | 13 | 55   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b> | 8. DATE OF BIRTH <b>6/28/96</b>                                    |    | 9. AGE (In years last birthday) <b>59</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance man</b> |                                | 10b. KIND OF BUSINESS OR INDUSTRY <b>Northeast Hospital</b>           | 11. BIRTHPLACE (City and State or Foreign Country) <b>Linn Mo.</b> |    | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |

|  |   |   |
|--|---|---|
| 13a. FATHER'S NAME <b>Henry Wolfe</b>  | 13b. MOTHER'S MAIDEN NAME <b>Mary Gertrude Krantz</b> | 14. NAME OF HUSBAND OR WIFE <b>Rose Ellen Wolfe</b>                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> | 16. SOCIAL SECURITY NO. <b>489-16-3194</b>            | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Rose Ellen Wolfe 144 No. Belmont</b> |

|  |   |  |                                  |
|--|---|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |
| *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. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Coronary Thrombosis</b>         |  | —                                |
|  | ANTECEDENT CAUSES   |  |                                  |
|  | DUE TO (b) <b>Arteriosclerotic heart disease</b>  |  | ?                                |
|  | DUE TO (c) <b>Arteriosclerosis</b>  |  | ?                                |
|  | II. OTHER SIGNIFICANT CONDITIONS  |  | 4/2000                           |
|  | Conditions contributing to the death but not related to the disease or condition causing death. |  |                                  |

|   |  |  |
|---|--|--|
| 19a. DATE OF OPERATION                          | 19b. MAJOR FINDINGS OF OPERATION <b>None</b>   | 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 Jan 15, 1955 to Sept 13, 1955, that I last saw the deceased alive on Sept 12, 1955, and that death occurred at 2 A.M., from the causes and on the date stated above.

|   |  |  |   |
|---|--|--|---|
| 23a. SIGNATURE (Date or title) <b>Frank E. Day M.D.</b> |  | 23b. ADDRESS <b>4314 29th St. K.C. Mo</b>  | 23c. DATE SIGNED <b>9-13-55</b>   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>9/15/55</b>                   | 24c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>                       | 24d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b> |
| DATE REC'D BY LOCAL REG. <b>9-14-55</b>                 | REGISTRAR'S SIGNATURE <b>Neva Marshall</b> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Sheil Funeral Home Kansas City Mo.</b> |   |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD Frank E. Day

51

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 Harold P. Reich Student Embalmer No. 51 working under my personal supervision..

Student Harold P. Reich  
Signature of Student Embalmer

Signed Thomas A. Reed

Licensed Embalmer No. 495

P. O. Address X.C. M.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.