

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014826
STATE FILE NUMBER

FILED APR 22 1958

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 37

S. 300

v. 1-57

5420

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sibley</u> <u>7000</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lexington Hospital</u>		Length of stay in lb <u>3 wks</u>	d. STREET ADDRESS (If outside, give location) <u>Rural, Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samaria Abigail Wulfekoetter</u>			4. DATE OF DEATH Month Day Year <u>April 6, 1958</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 6, 1958</u>
9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-keeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home Own</u>	11. BIRTHPLACE (City and state or country) <u>near Sibley, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>William Stewart</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Bridges</u>	14. NAME OF HUSBAND OR WIFE <u>Henry Wulfekoetter</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u> <u>xxx</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Lester Sommerville, San Lorenzo, Calif</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Acute myocardial infaction</u> DUE TO (c) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>7 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>2/15/58</u> to <u>4/6/68</u> and last saw her alive on <u>4/5/58</u> Death occurred at <u>12:57</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <u>Ben H. Brasher MD</u>		22b. ADDRESS <u>Lexington, Mo.</u>	22c. DATE SIGNED <u>4/9/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>4-8-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City of Wellington</u>	23d. LOCATION (City, town, or county) - (State) <u>Wellington, Missouri</u>
24. FUNERAL DIRECTOR <u>Ralph O Jones</u>		ADDRESS <u>Chelsea, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4-17-58</u>
		26. REGISTRAR'S SIGNATURE <u>Wm E. Eustace</u>	

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
Signature of Student Embalmer

Signed *Ralph J. Jones*

Licensed Embalmer No. *4604*
P. O. Address *Odean, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.