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Health,  
& Welfare  
Public  
Service

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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024495  
STATE FILE NUMBER

FILED AUG 13 1958 Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 161

1. PLACE OF DEATH a. COUNTY <b>Audrain</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Audrain</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mexico</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Mexico</b> <b>00430</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Audrain Hosp.</b>		Length of stay in lb <b>12 Days</b>	d. STREET ADDRESS (If outside, give location) <b>912 Carrico</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Perry</b> Middle <b>Brish</b> Last <b>Wolf</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>7,</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1890</b>		9. AGE (In years last birthday) <b>67</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS. <b>0</b>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocery Clerk</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	11. BIRTHPLACE (City and state or country) <b>Callaway Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>William Wolf</b>	13b. MOTHER'S MAIDEN NAME <b>Sallie L. Lynes</b>	14. NAME OF HUSBAND OR WIFE <b>Miss Nan Wolf</b>
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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>491-05-7818</b>	17. INFORMANT <b>Miss Nan Wolf</b>	Address <b>Mexico, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anterior Myocardial Septal Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7-27-58</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary Insufficiency - from history</b>	<b>3 months</b>
	DUE TO (c) <b>Second Myocardial infarction - with Periphery</b>	<b>8-6-58</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.) <b>X</b>
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20c. TIME OF INJURY Hour <b>X</b> Month, Day, Year a.m. <b>X</b> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, store, street, office bldg., etc.) <b>X</b>	20f. CITY, TOWN, OR LOCATION <b>X</b>	COUNTY	STATE
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21. I attended the deceased from <b>7-27-58</b> to <b>8-7-58</b> and last saw him alive on <b>8-7-58</b> Death occurred at <b>8-7-58</b> <b>7:20</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Harry F. O'Brien M.D.</b>	22b. ADDRESS <b>Merica Meriani</b>	22c. DATE SIGNED <b>8-8-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 9, 58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hickory Grove</b>	23d. LOCATION (City, town, or country) (State) <b>Boone Co., Mo.</b>
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24. FUNERAL DIRECTOR <b>Arnold Funeral Home</b>	ADDRESS <b>Mexico, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Aug 9-1958</b>	26. REGISTRAR'S SIGNATURE <b>Stenehe Geely</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Les S Whitaker* .....

Licensed Embalmer No. *4780* .....

P. O. Address *MEXICO, 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.