

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008304
STATE FILE NUMBER

FILED MAR 17 1959

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 27

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Watson</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fairfax Com. Hosp.</u>		Length of stay in lb <u>1 Wk.</u>	d. STREET ADDRESS (If outside, give location) <u>none</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Valentine Wolf.</u>			4. DATE OF DEATH Month Day Year <u>3 9 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1880</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR: Months <u>0</u> Days <u>5</u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Shop</u>	11. BIRTHPLACE (City and state or country) <u>Fremont Co. Iowa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13a. FATHER'S NAME <u>Geo. Wolf.</u>		13b. MOTHER'S MAIDEN NAME <u>Syrena Thayer</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Geo. Wolf.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs Ben Bregiele Watson. Mo.</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>Renal failure - uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cardiac decompensation</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4500</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 months</u> <u>10 yrs</u>
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"/> 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>Nov, 1956</u> to <u>March, 1959</u> and last saw ^{her} him alive on <u>3-9-59</u> Death occurred at <u>11:45</u> <u>P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Harvie R. Allan, M.D.</u>			22b. ADDRESS <u>Rock Port Mo</u>		22c. DATE SIGNED <u>3/10/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-11-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Linden Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Rock Port, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Bartholomew Mortuary, Rock Port.</u>			25. DATE RECD. BY LOCAL REG. <u>March 10, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Harwin H. Schoeler</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *Gritz Butcher*

Licensed Embalmer No. 3173
Rock Port. Mo.,
P. O. Address

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.