

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028178

FILED VS SEP 8 1959

Registration District No. 88 Primary Registration District No. 3006 Registrar's No. 420

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>4 1/2</u> Years		c. CITY OR TOWN <u>Columbia</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>1314 Anthony St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1314 Anthony St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle Last <u>WOLF</u>				4. DATE OF DEATH September 2, 1959				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1864</u>	9. AGE (last birthday) <u>95</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Repair</u>		11. BIRTHPLACE (City and state or country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Christine Wolf</u>			13b. MOTHER'S MAIDEN NAME <u>_____</u>			14. NAME OF HUSBAND OR WIFE <u>Wilhelmina Wagner</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Dorothy Wolf, 1314 Anthony, Columbia, 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>Arterio Sclerotic Heart Disease</u> DUE TO (b) <u>with decompensation.</u> DUE TO (c) <u>Chronic Myocarditis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>25 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 WORK <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 <u>Columbia</u>		COUNTY <u>Missouri</u>		STATE		
21. I attended the deceased from <u>1940</u> to <u>Sept. 2-1959</u> and last saw her/him alive on <u>Sept 2-1959</u> Death occurred at <u>5:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Carl S. Dutcher M.D.</u>				22b. ADDRESS <u>Prof Bldg. Columbia Mo</u>		22c. DATE SIGNED <u>9-4-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-5-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) <u>Columbia, Missouri</u>		(State)		
24. FUNERAL DIRECTOR ADDRESS <u>Parker Funeral Service, Columbia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Sept 4 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. W. Phillips

Licensed Embalmer No. 4897

P. O. Address Columbus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.