...I DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 2 8 1960

-60-039336

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 139

1. PLACE OF DEATH a. COUNTY Pulaski	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ft. Leonard Wood — Length of stay in 1b	c. CITY OR TOWN Ft. Leonard Wood — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital — Inside Limits Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location) US Army Hospital — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
William	Michael	Wolf	Oct	6	60

5. SEX	6. COLOR OR RACE	7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
Male	Cau		10-5-60				1	6

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
---	---	Ft. Leonard Wood, Mo.	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Vincent J. Wolf	Xoa Lee Decker	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	---	---	Vincent J. Wolf	22 Barger Street Ft. Leonard Wood, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Respiratory arrest

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Anencephaly

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Agenesis of adrenal glands

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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~~ saw the deceased ~~from~~ on 6 Oct 60, to ~~and last saw her alive on~~

Death occurred at 12:10 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
George F. Scofield GEORGE F. SCOFIELD, MC, MD	Ft. Leonard Wood, Mo.	6 Oct 60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	10-10-60	Post Cemetery	Ft Leonard Wood Missouri

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Hedges Funeral Homes Inc Crocker Mo		10-8-60	Eula Mae Anderson

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Clarence Mos

Signature of Student Embalmer

Licensed Embalmer No. 4896

P. O. Address Waynesville

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