

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-009923**

STATE FILE NUMBER

Registration District No. 243 Primary Registration District No. 4264 Registrar's No. 8

AMENDED FILED APR 14 1961

1. PLACE OF DEATH a. COUNTY <u>Newton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Stella</u>		Length of stay in lb <u>16 yrs</u>	c. CITY OR TOWN <u>Stella</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>Cardwell Memorial Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Stella</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Magdaline</u> Last <u>Wolfe</u>			4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>Female</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>7-14-1891</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Bentonville, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Charles Dopp</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Cooper</u>		14. NAME OF HUSBAND OR WIFE <u>Tim J. Wolfe</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 <u>Tim J. Wolfe</u>		Address <u>Stella, Mo.</u>	

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) <u>Cerebral Hemorrhage</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension</u>		
DUE TO (c) <u>Arteriosclerosis and senility</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 <u>10:50</u> a.m. Month, Day, Year <u>1/31/61</u>	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	COUNTY STATE

21. I attended the deceased from 1/31/61 to 2/7/61 and last saw her/him alive on 2/7/61  
Death occurred at 10:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>Cardwell Memorial Hosp. Stella, Mo.</u>	22c. DATE SIGNED <u>2-2-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-11-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Macedonia Cem.</u>
23d. LOCATION (City, town, or county) (State) <u>Stella, Mo.</u>		

24. FUNERAL DIRECTOR <u>W. Morris Foye</u>	ADDRESS <u>Stella, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-1-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
---	-------------------------------	---	---

DATE AWARDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 James Kenyth Dunc

Licensed Embalmer No. 4767

P. O. Address Wheaton 7

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.