

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035517  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Primary Registration District No. 500 Registrar's No. 2680

FILED SEP 27 1961

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF  
ITEM NO.

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>ST. CLAIR</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		Length of stay in 1b <b>8 DAYS</b>	c. CITY OR TOWN <b>EAST ST. LOUIS</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>VETERANS ADMINISTRATION HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>526 N. 29th STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN F. WOLFE</b>			4. DATE OF DEATH Month Day Year <b>9-22-61</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-1970</b>
9. AGE (last birthday) <b>91</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LIVE STOCK REPORTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NATIONAL STOCK YARDS</b>	11. BIRTHPLACE (City and state or country) <b>FLORA, ILLINOIS</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>MARTON WOLFE</b>	
13b. MOTHER'S MAIDEN NAME <b>RECKY WYMAN</b>		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES SPAW</b>		17. INFORMANT Address <b>MR. SOGE WOLFE, 526 N. 29th, E. ST. LOUIS, ILL</b>	
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>ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 YEARS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ASTHMA</b>			<b>60 YEARS</b>
DUE TO (c) <b>CHRONIC BRONCHITIS</b>			<b>20 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>OBSTRUCTIVE EMPHYSEMA</b>			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	COUNTY STATE
21. I attended the deceased from <b>9-14-61</b> to <b>9-22-61</b> and <del>was present</del> Death occurred at <b>9:45 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>W.P. Hamilton</i> (Degree or title)		22b. ADDRESS <b>M.D. VA HOSP. JEFF. BRKS. MO.</b>	22c. DATE SIGNED <b>9-22-61</b>
23a. BURIAL, CREMATION, or OTHER DISPOSAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>RETROVAL</b>	<b>9-24-1961</b>	<b>Greenwood</b>	<b>St. Clair Co., Ill.</b>
24. FUNERAL DIRECTOR <b>KURRUS FUNERAL HOME EAST ST. LOUIS, ILL.</b>		25. DATE RECD. BY LOCAL REG. <b>9/22/61</b>	26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>

**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

*NOT Embalmed*  
*Ch. Kurus Jr*

Licensed Embalmer No. 3162

P. O. Address East St. Louis, Ill.

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.