

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-040252

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1168

FILED NOV 24 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 38 years	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2214 Delmar St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2214 Delmar St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First FINNIS Middle HENRY MIKE Last WOLFE			4. DATE OF DEATH Month November Day 15 Year 1961		
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/23/1910	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) trucker		10b. KIND OF BUSINESS OR INDUSTRY Trucking	11. BIRTHPLACE (City and state or country) Guilford, Mo.	12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Phillip Wolfe	13b. MOTHER'S MAIDEN NAME Nora Foster	14. NAME OF HUSBAND OR WIFE Ruby
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Ruby Wolfe, 2214 Delmar St., St. Joseph,		Address

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) Multiple cerebral hemorrhages with left hemiplegia		Unknown
DUE TO (b) Generalized Arteriosclerosis		Unknown
DUE TO (c)		

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
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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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year	
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 10/20/61 to 11/15/61 and last saw him alive on 11/14/61
Death occurred at 9:02 a. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>D.F. Sklenen M.D.</i>	22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.	22c. DATE SIGNED 11/16/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11/17/1961	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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24. FUNERAL DIRECTOR <i>Hector - Bowman,</i>	ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. Nov. 21, 1961	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Standell</i>
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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

4/9/62

DOCUMENT

BY AFFIDAVIT OF Funeral Director

Add "Mike"

D.F. Sklenen, M.D. MEDICAL CERTIFICATION

NOV 29 1967

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 Eugene Wood

Licensed Embalmer No. 5804

P. O. Address 319 1/2 10th St. H. J.

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.