

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027868

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

119

Primary Registration District No.

5993

Registrar's No.

39

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Gasconade		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Gasconade	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Roark Twp.		c. CITY OR TOWN Hermann	
Length of stay in 1b 3 Wks.		Inside Limits ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Frene Valley Nursing Home		d. STREET ADDRESS (If outside, give location) E. 5th. St.	
3. NAME OF DECEASED (Type or print) First FRANCES Middle MARGARITA Last WOLFF		4. DATE OF DEATH Month July Day 9 Year 1963	
5. SEX Female	6. COLOR OR RACE Cau.	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH 6-29-1879
9. AGE (last birthday) 84		IF UNDER 1 YEAR Months ☐ Days ☐ Hours ☐ Min. ☐	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (City and state or country) Altona, Germany		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Franz Keune		13b. MOTHER'S MAIDEN NAME William Wolff	
14. NAME OF HUSBAND OR WIFE William Wolff		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. None		17. INFORMANT Riley Roberson -- Hermann, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC HEART DISEASE			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC CHOLECYSTITIS			
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 the deceased from 11-15-57 to 7-9-63 and last saw her alive on 7-5-63 Death occurred at 7:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Thoma M. Workman M.D.		22b. ADDRESS Hermann, Missouri	
22c. DATE SIGNED 7-10-63		23a. BIRTHPLACE (City and state or country) Hermann, Missouri	
23b. DATE 7-12-1963	23c. NAME OF CEMETERY OR CREMATORY Hermann Cemetery	23d. LOCATION (City, town, or county) Hermann, Missouri	
24. FUNERAL DIRECTOR HERMAN BLUMER, INC. HERMANN, MO.	25. DATE RECD. BY LOCAL REG. 7-11-63	26. REGISTRAR'S SIGNATURE Delma Uffelman	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

JUL 24 1963

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 Quell R. Grover

Licensed Embalmer No. 5187

P. O. Address Hermann, Mo.

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.