

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0034427

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

1082

FILED SEP 27 1967

1. PLACE OF DEATH

a. COUNTY

Buchanan

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

St Joseph

Length of stay in 1b

2 weeks

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

Methodist Hosp,

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

DeKalb

c. CITY

OR TOWN

Maysville

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Sadona

Middle

Last

Wolf

4. DATE OF DEATH

Month

9

Day

19

Year

67

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

12-28-1884

9. AGE (last birthday)

82

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (City and state or country)

Mo

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

William Johnson

13b. MOTHER'S MAIDEN NAME

Mary Geise

14. NAME OF HUSBAND OR WIFE

none

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.

497-40-6596

17. INFORMANT

Paul Wolf

Address

Weatherby Mo.

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

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Failure

DUE TO (b)

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

DUE TO (c) Hypertensive HEART Disease

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.

☐ Yes ☐ No ☐ Unknown19. 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 9-9-67 to 9-19-67 and last saw her alive on 9-19-67
Death occurred at 12:30 p.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

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

9-21-67

23c. NAME OF CEMETERY OR CREMATORY

Fairport

23d. LOCATION (City, town, or county)

Fairport

(State)

Mo.

24. FUNERAL DIRECTOR

ADDRESS

John Bram

Maysville Mo.

25. DATE RECD. BY LOCAL REG.

9-26-67

26. REGISTRAR'S SIGNATURE

Mary Volentine

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

H.C. Senne, M.D. MEDICAL CERTIFICATION

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

John Brown

Licensed Embalmer No.

3933

P. O. Address

Waycross, 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.

Received and 9.9.17
M...