

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 411

Primary Registration District No. 2002

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
In this community 42 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME John Jay Wolfe 410
8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced marrie
6. (b) Name of husband or wife Minnie Crafton 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 17, 1873
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Wise County Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation Lawyer

11. Industry or business Dr. Joseph Wolfe

MOTHER FATHER { 12. Name _____
13. Birthplace Virginia
(City, town, or county) (State or foreign country)

{ 14. Maiden name Sarah Horton
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. John Wolfe
(b) Address _____

17. (a) Burial (b) Date thereof 12-4-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director J. P. Reynolds
(b) Address 1502 Joplin Street, Joplin

19. (a) 12-4-39 (b) Ed S. Jensen
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Joplin
(If outside city or town limits, write "RURAL")
(d) Street No. 305 N. Moffet
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 2nd
year 1939 hour 2:45 minute _____ D. M.

21. I hereby certify that I attended the deceased from November 28, 1939 to Dec 2, 1939
that I last saw him alive on Nov 28, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral occlusion Duration 7 days
Due to Anemia
Due to 9H
Other conditions Anemia
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: None
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
(e) Means of injury _____
23. Signature Fred L. Huff (M. D. or other) _____
Address Joplin Mo Date signed 12/4/39

RECEIVED

District Health Officer No. 6,

District File Number 1010-1010

Date Filed JAN 10 1940

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Japhin M

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 this body is not embalmed, above space should be left blank.