

FILED FEB 21 1940

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

3369  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Phelps Registration District No. 677  
 (b) Township Rolla Primary Registration District No. 4403 Registered No. 6  
 (c) City Rolla (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ethel Wolfe

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 25, 1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
54 5 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Railroad  
 9. Industry or business in which work was done, as saw mill, bank, etc. Employee  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) St James (STATE OR COUNTRY) Mo

FATHER 13. NAME John C Wolfe 0

14. BIRTHPLACE (CITY OR TOWN) St James (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Sarah O'Neil

16. BIRTHPLACE (CITY OR TOWN) St James (STATE OR COUNTRY) Mo

17. INFORMANT Mrs Ethel Wolfe (ADDRESS) Rolla Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Adams Cem DATE 1/9 19 40

19. FUNERAL DIRECTOR (NAME) Mrs Harry McCaw (ADDRESS) Rolla Mo

20. FILED Jan 9 19 40 Jos. F. Ayers Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/6 19 40

22. I HEREBY CERTIFY, That I attended deceased from 1-4, 1940, to 1-6, 1940

I last saw him alive on 1-6- 19 40 Death is said

to have occurred on the date stated above, at 9:30 am.

The principal cause of death and related causes of importance were as follows:

General Peritonitis  
Peritonitis

Date of onset

Other contributory causes of importance:   
Liver abscess

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) B. E. F. Ford M. D.

(Address) Rolla, Mo.

12578

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**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.

**RECEIVED**

District Health Officer No. 5,

Signed.....

District File Number 240220

Licensed Embalmer No.....

Date Filed 21640

P. O. Address.....

**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.**

2B  
21-40  
22859

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**  
 (a) County Rhels  
 (b) City or town Rolla  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

**3. (a) PRINT FULL NAME** John C. Wolfe  
**3. (b) If veteran, name war** \_\_\_\_\_ **3. (c) Social Security No.** \_\_\_\_\_

**4. Sex** \_\_\_\_\_ **5. Color or race** \_\_\_\_\_ **6. (a) Single, widowed, married, divorced** \_\_\_\_\_  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband, or wife, if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

**8. AGE:** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

**10. Usual occupation** \_\_\_\_\_

**11. Industry or business** \_\_\_\_\_

**12. Name** \_\_\_\_\_

**13. Birthplace** \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

**14. Maiden name** \_\_\_\_\_

**15. Birthplace** \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

**16. (a) Informant** \_\_\_\_\_

**(b) Address** \_\_\_\_\_

**17. (a)** \_\_\_\_\_ **(b) Date thereof** \_\_\_\_\_ (Month) (Day) (Year)  
 (Burial, cremation, or removal)

**(c) Place: burial or cremation** \_\_\_\_\_

**18. (a) Signature of funeral director** \_\_\_\_\_

**(b) Address** \_\_\_\_\_

**19. (a)** \_\_\_\_\_ **(b)** \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH** Month 1 day 6  
 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from** \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death General peritonitis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Liver abscess  
 (Include pregnancy within 3 months of death) cause not known  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 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** E. E. Fend (M. D. or other) \_\_\_\_\_  
 Address Rolla Mo Date signed \_\_\_\_\_

SUPPLEMENTAL

S-3369