

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

**28394**

Do not use this space.

1. PLACE OF DEATH **SEP 19 1940**

(a) County De Kalb Registration District No. 2634

(b) Township Dallas Primary Registration District No. 5360 Registered No. \_\_\_\_\_

(c) City Santa Rosa, Mo. (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_

(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 AMC Amanda Catherine Wolf

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas Wolf

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3/16/1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

77      4      18

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. House Wife

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

FATHER

13. NAME Abraham Chaney

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K Y

MOTHER

15. MAIDEN NAME Paline Chaney

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

17. INFORMANT Thomas Wolf (ADDRESS) Santa Rosa, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Fairport, Mo. DATE 8/6/40, 1940

19. FUNERAL DIRECTOR (NAME) W. G. Gomer (ADDRESS) Pattonburg, Mo. 238

20. FILED Sept 4, 1940 James Fitzgerald Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 4 1940

22. I HEREBY CERTIFY, That I attended deceased from June 25, 1940, to Aug 1, 1940

I last saw him alive on Aug 1, 1940 Death is said to have occurred on the date stated above, at 8:15 P.M.

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

Arterio insufficiency

Date of onset

Other contributory causes of importance: g2w

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 \_\_\_\_\_, 1940

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? \_\_\_\_\_

If so, specify Frank Hedgick /, M. D. (Signed) Pattonburg (Address) \_\_\_\_\_

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.

RECEIVED

District Health Officer No. 11,  
District File Number 940-1341

Date Filed

SEP 9 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 E. Schomer

Licensed Embalmer No. 2857

P. O. Address Pittsburg

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

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