

Registration District No. 547 Primary Registration District No. 3029 State File No. 327
 DEC 17 1940

1. PLACE OF DEATH:
 (a) County MARION
 (b) City or town HANNITA
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: STERILIZABETH HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 21 days
 In this community 21 days
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County MONROE
 (c) City or town MONROE CITY
 (If outside city or town limits, write "RURAL")
 (d) Street No. 8 Cleveland St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME WILLIAM ANDREWS WOOLFOLK
 (b) If veteran, name war. NO
 (c) Social Security No. 197-65-2113

4. Sex MALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED
 (b) Name of husband or wife Elizabeth Woolfolk
 (c) Age of husband or wife if alive 59 years
 7. Birth date of deceased FEB 3 1874
 (Month) (Day) (Year)

8. AGE: Years 66 Months 9 Days 18
 If less than one day hr. min.

9. Birthplace P.K. MISSOURI
 (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

MOTHER FATHER
 12. Name John Lewis Woolfolk
 13. Birthplace P.K. KY INDIAN
 (City, town, or county) (State or foreign country)
 14. Maiden name Mattie Ann Yeager
 15. Birthplace P.K. MISSOURI
 (City, town, or county) (State or foreign country)

16. (a) Informant Blandie Daniel
 (b) Address 421 Madison, Hannita

17. (a) Burial (b) Date thereof Nov. 23 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST STEPHENS CEMETARY

18. (a) Signature of funeral director WILSON & SON
 (b) Address MONROE CITY MO

19. (a) Nov 22 1940 (b) W.D. Fishers
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21
 year 1940 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Nov 10 1940 to Nov 21 1940

that I last saw him alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Failure

Due to Pericranial aneurysm

Due to Cristate Resection

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 W.D. Fishers (M. D. or other)

Address Monroe City Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1327

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 Leslie L. Wilson

Licensed Embalmer No. 3014

P. O. Address Monroe City, Mo.

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 39207

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal
(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 _____
In this community _____ (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME Wm Andrews Wool Folk

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 9 18 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 11 day 21
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 Cerebratory failure Duration _____

Due to benign anemia

Due to prostatic resection

Other conditions (include pregnancy within 3 months of death) 127

Major findings: Of operations Hypertrophy of prostate

Of autopsy _____

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)
(c) Means of injury _____

23. Signature [Signature] (M. D. or D. O.)
Address [Address] Date signed Jan 27

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

SUPPLEMENTARY

S-39207 1940