

5-17-39
PI X23159

State File No. _____

Registration District No. 744

Primary Registration District No. 5974B

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Henretta Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution All Her Life (Specify whether years, months or days)

In this community All Her Life

3. (a) PRINT FULL NAME Dora F. Wolfe

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive 18.88

7. Birth date of deceased January 19th, 1922
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>		<u>3</u>	hr. _____ min.

9. Birthplace Versales Mo. me D
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

12. Name James W. Browne

13. Birthplace Versales Mo. A
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Brown

15. Birthplace Versales Mo. A
(City, town, or county) (State or foreign country)

16. (a) Informant William E. Wolfe

(b) Address Henretta Mo.

17. (a) Burial (b) Date thereof Jan. 24-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Quincy Slope

18. (a) Signature of funeral director J. T. B. Smith

(b) Address Richmond Mo.

19. (a) Jan. 23-41 (b) Malcolm Jackson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray

(c) City or town Henretta Mo.
(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. U.S.A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22nd year 1941 hour 1.50 A. Minute _____ M.

21. I hereby certify that I attended the deceased from July/19th 1940 to 1/22nd 1941

that I last saw her alive on January 22nd 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Lymphatic Cancer of Bowels and Stomach

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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? Yes

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. V. Smith (M. D. or other) A

Address Henrietta, Mo. Date signed 1/22/41

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

89
0
0

46

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-13-41

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.....

J.B. Brothers

....., Registered Apprentice No.....

working under my personal supervision.

Brothers Funeral Home

Signed.....

J.B. Brothers

Licensed Embalmer No..... 3001

P. O. Address..... **Richmond 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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4030

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 744

Primary Registration District No. 5976 B.

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Richmond, T.P.
(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 Dora F Wolfe

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

4. Sex F 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 _____ years

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

8. AGE: Years 59 Months - Days 3 If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 Jan day 27
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Lymphatic cancer of bowels and stomach

Due to Primary carcinoma
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

