

No. 1-4 1-17

Registration District No. 470

Primary Registration District No. 5633

Registrar's No. 99

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mount Vernon *T.B.*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1391 days
(Specify whether _____)

In this community 1391 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 2611 Olive
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Gertrude Wolff

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25th
year 1941 hour 10:55 minute _____ P. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Milton L. Wolff

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

7. Birth date of deceased July 15th 1906
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 2d 1937 to June 25 1941
that I last saw her alive on June 25th 1941
and that death occurred on the date and hour stated above.

8. AGE: Years 34 Months 11 Days 11
If less than one day _____ hr. _____ min.

Immediate cause of death Pulm. E.D.C. At 5:40

9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

10. Usual occupation Housewife

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

11. Industry or business _____

MOTHER FATHER { 12. Name Bert Chandler

13. Birthplace Hiawatha Kansas
(City, town, or county) (State or foreign country)

14. Maiden name Mary Marx

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant E. McMichael Record Clerk

(b) Address Missouri State Sanatorium

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? _____

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

(c) Place: burial or cremation St. Joseph

18. (a) Signature of funeral director J. H. ...

(b) Address 1946 Cahoon St. Joseph, Mo.

19. (a) 6-26-1941 (b) P.A. Holmes
(Date received local registrar) (Registrar's signature)

23. Signature Paul T. Medin (M. D. 1)
Address Mo. State San. Date signed 6-26-41

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

005

PP

SEP 8 1941

RECEIVED
 District Health Officer No. 6,
 District File Number 741-1034
 Date Filed JUL 7 1941

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.....

Licensed Embalmer No.....

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, fact should be so stated above.

P.A. H. 1034

1034

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22055

Registration District No. 478

Primary Registration District No. 5633

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town _____
(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 Gertrude Wolff

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 _____ year

7. Birth date of deceased July 15 1906
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ 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) Burial (b) Date thereof 6-26-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-26-41 (b) pa Holmes
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 25
year 1941 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

SEP 8 1941