

FILED MAY 10 1943

Registration District No. 1040  
Primary Registration District No. 3076

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

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Nevada, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
243 North Pine  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon  
(c) City or town Nevada  
(If outside city or town limits, write "RURAL")  
(d) Street No. 243 North Pine  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles William Wolfe

3. (b) If veteran, name war Korea  
3. (c) Social Security No. 491-05-8258

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Martha Ellen Wolfe  
6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased January 10 1873  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
70 2 22 17 hr. \_\_\_\_\_ min.

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

10. Usual occupation Minister

11. Industry or business

12. Name Rev. M. A. Wolfe  
13. Birthplace Kokomo Indiana  
(City, town, or county) (State or foreign country)  
14. Maiden name Lucinda Collins  
15. Birthplace Kokomo Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Dollie Wolfe

(b) Address 243 N. Pine Street

17. (a) Burial (b) Date thereof April 4-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newton Burial Park

18. (a) Signature of funeral director Funeral Home

(b) Address Nevada Mo

19. (a) 4-16-43 (b) Hazel B Beurek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2  
year 1943 hour \_\_\_\_\_ minute 5-0 M.

21. I hereby certify that I attended the deceased from Jan 10 1942 to Apr 2 1943  
that I last saw him alive on April 2 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis - Acute  
Duration 48 hrs

Due to A general decline following a hemorrhage from bowels about Jan 1

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)  
(c) Means of injury \_\_\_\_\_

23. Signature J. N. Love (M. D. or other)  
Address Nevada, Mo. Date signed 4/12/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 7,  
District File Number 4-43-196  
Date Filed 5-7-43

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 L. B. Ferry  
Licensed Embalmer No. 1760  
P. O. Address Nevada 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. 10748

Registration District No. 360

Primary Registration District No. 3076

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Wernon  
(b) City or town Wernon Nevada  
(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 \_\_\_\_\_ (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
(Immediate cause of death) myocarditis  
Duration 48 hr

3. (a) PRINT FULL NAME Charles Wm Wolfe  
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 \_\_\_\_\_ years

7. Birth date of deceased: Jan 10 (Month) (Day) (Year)

8. AGE: Years 70 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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)

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

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

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

Due to a general decline following a hemorrhage from stomach ulcer

Due to \_\_\_\_\_

Other conditions I was not treating Mr. Wolfe when this happened

Major findings: was supposed to have taken place. No evidence of tumor or tuberculosis.

Of all causes a general decline, Physically

22. If death was due to external causes, specify the cause to which death should be charged as \_\_\_\_\_

(a) Accident, suicide, or homicide (specify) that I could find

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(b) 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 J. N. Love (M. D. or other) \_\_\_\_\_

Address Nevada, MO Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

5-15748