

S. No. 2
M-8-43
5-17-39
X37623

20984

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FEB JUL 12 1945
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 2557 Primary Registration District No. 5820-4389

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Osage
(b) City or town Linn
(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 Life years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Osage
(c) City or town Linn, Mo.
(If outside city or town limits, write "RURAL") _____
(d) Street No. _____ (If rural, give location) _____
(e) Citizen of foreign country? No. (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME Mary Elize beth Wolff
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 2nd, year 1945 hour 4 minute 30 p. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Nickloas Wolff 6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased December 7th, 1863 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-18-45 1945 to 7-2-45 1945; that I last saw her alive on 7-2-45 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>6</u>	<u>16</u>	hr. _____ min. _____

Immediate cause of death: Hypostatic pneumonia
Due to Cerebral Hemorrhage
Due to Arteriosclerosis
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: (a) (b) (c)
Of operations _____
Of autopsy _____

9. Birthplace Richland, Missouri (City, town, or county) (State or foreign country) 1
10. Usual occupation House wife

11. Industry or business _____
12. Name G. Warrick
13. Birthplace Virginia (City, town, or county) (State or foreign country) 1
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country) 9

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

16. (a) Informant John Wolff
(b) Address Linn, Mo. R D.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/45 (Month) (Day) (Year)
(c) Place: burial or cremation Liberty Cemetary

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? _____

18. (a) Signature of funeral director Clyde Morton
(b) Address Linn, Mo.
19. (a) 7-4-45 (Date received local registrar) (b) T. A. Duprouillet (Registrar's signature)

While at work? _____ (Specify type of place) (b) Means of injury _____
23. Signature Joseph W. Bell (M. D. or other) 7-2-45
Address _____ Date signed 7-2-45

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

16
5
0

1280

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 7-11-45

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 Victor Buescher

Licensed Embalmer No. 3701

P. O. Address Jefferson City, Mo.

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

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