

FILED AUG 22 1945

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DOA at General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 years
years, months or days)

3. (a) PRINT FULL NAME Mary Curtis Wolff
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Fe 3 5. Color or race Col
6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 24 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 7 7 hr. _____ min.

9. Birthplace Dennison Texas
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

MOTHER FATHER
11. Industry or business _____
12. Name Jake Campbell
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Adeline
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Fritz Henderson
(b) Address 1728 Campbell

17. (a) burial (b) Date thereof 8/16/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Watkins Bros.
(b) Address 1729 Lydia

19. (a) 8-6-45 (b) Heraldine Holmea
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City ?
(If outside city or town limits, write "RURAL")
(d) Street No. 1728 Campbell 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1st
year 1945 hour 12:35 minute A. M.

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

Immediate cause of death _____
Due to Hypertensive Heart Disease
Due to _____
Other conditions 93 d
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy Hypertensive Heart Disease

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 H. Williams (M. D. or other) Deputy Coroner
Address 2636 Brooklyn Date signed 8/16/45

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

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

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

working under my personal supervision.

Registered Apprentice No.

Signed

J. Manlove

Licensed Embalmer No.

3444

P. O. Address

2503 Highland

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Sent9307Registration District No. 149Primary Registration District No. 1002Registrar's No. 9307

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas city
 (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 Mary C. Wolf

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced Widow6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased Dec 21 1899
(Month) (Day) (Year)8. AGE: Years 54 Months _____ Days _____ If less than one day _____ 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-6-45 (Date received local registrar) (b) Steraldine Holmes (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 _____, year 1945, 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 _____

Duration _____

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? _____

While at work? _____ (Specify type of place)

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

S-26664