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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAY 13 1946

State File No. 12099

Registration District No. 4 Primary Registration District No. 5024 Registrar's No.

1. PLACE OF DEATH:

(a) County ATCHISON

(b) City or town RURAL - SO. POLK. TWSP (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ATCHISON 3

(c) City or town RURAL - SO-POLK TWSP. 0 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME TOLLIE WOLF

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife ANNA BOETTNER

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased 8 (Month) 25 (Day) 1882 (Year)

8. AGE: Years 64 Months 8 Days 4 If less than one day hr. min.

9. Birthplace ROCK PORT (City, town, or county) MO 0 (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

FATHER
12. Name J. H. WOLF
13. Birthplace ROCK PORT (City, town, or county) MO 0 (State or foreign country)

MOTHER
14. Maiden name LOUETTA SPARKS
15. Birthplace STORY CO. (City, town, or county) IOWA 1 (State or foreign country)

16. (a) Informant Orville Wolf
(b) Address Rock Port Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-1-46 (Month) (Day) (Year)
(c) Place: burial or cremation LINDEN CEM.

18. (a) Signature of funeral director Barthalomew Montuary
(b) Address Rock Port, Mo

19. (a) 5-1-46 (Date received local registrar) (b) Betty Crabtree (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 29 year 1946 hour 3 minute A M.

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

	Duration
Immediate cause of death SELF INFLICTED GUN SHOT IN HEAD	
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.

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22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) SUICIDE

(b) Date of occurrence APRIL 29-1946

(c) Where did injury occur? 4 MILES N ROCKPORT (City or town) ATCHISON (County) (State) MO

(d) Did injury occur in or about home, on farm, in industrial place, in public place? IN BED ROOM OF HOME ~~OR~~ FARM (Specify type of place)

While at work? (e) Means of injury

23. Signature Chas F Fay DC (M. D. or other) 4/28/46

Address Westboro Mo Date signed

Coroner

(Licensed Embalmer's Statement on Reverse Side)

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. Gratz Bartholomew

Licensed Embalmer No. 3173

P. O. Address. Rock Port, 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.