No. 300
—10-47
5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAR 23 1948

Registration District No. 19

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5375

State File No. 8320

Registrar's No. 19

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

1. PLACE OF DEATH:

(a) County De Kalb

(b) City or town Pattonsburg Rural Dallas Twp Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community Entire life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Twp Mo (b) County De Kalb

(c) City or town Pattonsburg
(If outside city or town limits, write "RURAL")

(d) Street No. Rural 32
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Thomas Wolf.

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Amanda C Wolf.

6. (c) Age of husband or wife if alive (Dec'd) years

7. Birth date of deceased Jan (Month) 25 (Day) 1863 (Year)

8. AGE: Years 85 Months 1 Days 17 If less than one day hr. min.

9. Birthplace Fairport (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation

11. Industry or business Farmer.

FATHER
12. Name John W Wolf
13. Birthplace (City, town, or county) Gy. 4 (State or foreign country)

MOTHER
14. Maiden name Charlotte Smith
15. Birthplace (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Floyd Wolf
(b) Address Pattonsburg Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof 3-12-48 (Month) (Day) (Year)
(c) Place: burial or cremation Fairport

18. (a) Signature of funeral director Isaac L Gromer
(b) Address Pattonsburg

19. (a) 3-15-48 (Date received local registrar) (b) R Davidson (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Mar day 12
year 1948 hour 10:20 minute A M.

21. I hereby certify that I attended the deceased from May 12, 1945, to Mch 12, 1948
that I last saw h — alive on Dec 23, 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	
Due to Mob's Brightie	
Due to Artesia Sclerosis	
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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature M. S. Gale (M. D. or other)

Address Osborn Mo. Date signed 3/12/48

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 T V Dunham, Registered Apprentice No. 50, working under my personal supervision.

Signed Lea L Gromer

Licensed Embalmer No. 3022

P. O. Address Pattonsburg 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.

No. 2B
5-5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April 19

Registration District No. 99 Primary Registration District No. 5375 Registrar's No.

1. PLACE OF DEATH:

(a) County: DeKalb

(b) City or town: Rural
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: DeKalb.

(c) City or town: Pattonsburg - Rural - DALLAS Twp.
(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

3. (a) PRINT FULL NAME: Thomas Wall

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: Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased: Jan 25 1864 (Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 2 year 1948 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.

	Duration
Immediate cause of death	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

1948