

No. 300
10. 48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30463

State File No.

BIRTH NO. _____ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 3071 Registrar's No. 38

1. PLACE OF DEATH
a. COUNTY **Saline**
b. CITY OR TOWN **Slater**
c. LENGTH OF STAY (in this place) _____
d. FULL NAME OF HOSPITAL OR INSTITUTION **none**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE **Mo.**
b. COUNTY **Saline**
c. CITY OR TOWN **Slater**
d. STREET ADDRESS **237 Parker**

3. NAME OF DECEASED
a. (First) **Joseph**
b. (Middle) **D.**
c. (Last) **Wolfskill**

4. DATE OF DEATH
(Month) (Day) (Year)
Aug. 12-1952

5. SEX **male**

6. COLOR OR RACE **white**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
widower

8. DATE OF BIRTH
May, 4th 1863

9. AGE (In years last birthday) **89**
IF UNDER 1 YEAR Months **3** Days **8**
IF UNDER 24 HRS. Hours **8** Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
at home

10b. KIND OF BUSINESS OR INDUSTRY
none

11. BIRTHPLACE (State or foreign country)
Saline Co. Mo.

12. CITIZEN OF WHAT COUNTRY?
U S

13a. FATHER'S NAME
Joe Wolfskill

13b. MOTHER'S MAIDEN NAME
Lou Watson

14. NAME OF HUSBAND OR WIFE
none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no**
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.
none

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Miss Flossie Wolfskill Slater, Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Bronchopneumonia**
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last:
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. **Mitral Regurgitation**

INTERVAL BETWEEN ONSET AND DEATH
3 days

about 20 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
491x

20. AUTOPSY?
YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8-11**, 19**52**, to **8-12**, 19**52**, that I last saw the deceased alive on **8-12**, 19**52**, and that death occurred at **8** **A** m., from the causes and on the date stated above.

23a. SIGNATURE **B. A. Sullivan** (Degree or title) **M.D.**

23b. ADDRESS **Miami, Missouri**

23c. DATE SIGNED **8-13-1952**

24a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24b. DATE **8/14/52**

24c. NAME OF CEMETERY OR CREMATORY
City Cemetery

24d. LOCATION (City, town, or county) (State)
Slater, Mo.

DATE REC'D BY LOCAL REG.
8/15/1952

REGISTRAR'S SIGNATURE
Mrs. Earl C. McNeill

FUNERAL DIRECTOR'S SIGNATURE ADDRESS
C. McNeill Brothers, Slater, Mo.

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

971
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed A. C. Hill

Licensed Embalmer No. 3090

P. O. Address State 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.