

FILED NOV 1 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33152

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1107</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>35 yrs.</u>		c. CITY OR TOWN <u>St. Joseph</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>114 Ohio St.</u>				e. STREET ADDRESS (If rural, give location) <u>114 Ohio St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u>			b. (Middle) <u>L</u>		c. (Last) <u>WOLFE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 19, 1954</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>Feb. 2, 1885</u>		9. AGE (In years last birthday) <u>69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry house</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Peter Wolfe</u>			13b. MOTHER'S MAIDEN NAME <u>Julia (Unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>499-20-3919</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Rosie Gieber 114 Ohio St.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Transitional cell carcinoma of bladder</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Ukn.</u>
				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.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>181X</u>			
22. I hereby certify that I attended the deceased from <u>8-5-1954</u> , to <u>10-19-1954</u> , that I last saw the deceased alive on <u>10-18-1954</u> , and that death occurred at <u>6:10p</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Martin H. Olnet, M.D.</u>				23b. ADDRESS <u>202 Park + Surge Bldg, City</u>		23c. DATE SIGNED <u>10-21-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Oct. 21, 54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lancaster Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Lancaster, Kansas</u>		
DATE REC'D BY LOCAL REG. <u>Oct 25, 1954</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Clark Funeral Home St. Joseph, Mo.</u>			

WRITE PLAINLY—USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Emma Clark*

Licensed Embalmer No. *423*

P. O. Address *St. J...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.