

FILED APR 9 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8495**

BIRTH NO. _____ REG. DIST. NO. **73** PRIMARY REG. DIST. NO. **5291** Registrar's No. **34**

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, give RURAL and give OR TOWN Liberty - Rural)		c. LENGTH OF STAY (in this place) 17 hrs.	c. CITY OR TOWN Liberty Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION IOOF Hospital		e. STREET ADDRESS (If rural, give location) RR 3	
3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) M. c. (Last) Wolff		4. DATE OF DEATH (Month) (Day) (Year) Mar. 24, 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH April 26, 1872
9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Clerk		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John M. Wolff	
13b. MOTHER'S MAIDEN NAME Ada Geisler		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Tom Weaver, Liberty, 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) Seil Arteriosclerosis encephalomalacia		INTERVAL BETWEEN ONSET AND DEATH 39 hrs	
		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)	332X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR		

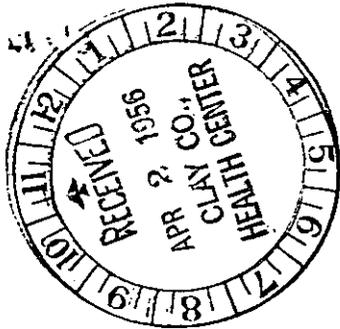
22. I hereby certify that I attended the deceased from 1950, to Mar 23, 1956, that I last saw the deceased alive on Mar 23, 1956, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm H. Goodson M.D.	23b. ADDRESS Liberty Mo	23c. DATE SIGNED 3/24/56
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE March 24, 1956	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery, St. Louis, Mo.
24d. LOCATION (City, town, or county) (State)		

DATE REC'D BY LOCAL REG. 3-31-56	REGISTRAR'S SIGNATURE Mabel Strahan	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Tyler Parley, Liberty, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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 *Charles A. Tyle*.....

Licensed Embalmer No. *45*.....

P. O. Address *Liber*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.