

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005189

STATE FILE NUMBER

Dr. Epps

FILED MAR 3 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 191

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hosp.		Length of stay in lb 12 Yrs.	d. STREET ADDRESS (If outside, give location) 722 S. Jefferson		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LORENA Middle Last WOLFE			4. DATE OF DEATH Month Feb. Day 23 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12 1902		9. AGE (In years of birthday) 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Senior Teacher		10b. KIND OF BUSINESS OR INDUSTRY Grade School		11. BIRTHPLACE (City and state or country) Morgan, Texas	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME G.G. Tripp		13b. MOTHER'S MAIDEN NAME Addie Reed		14. NAME OF HUSBAND OR WIFE Ernest Wolfe	
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. ?	17. INFORMANT Frank Wolfe Address Springfield, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinomatosis					INTERVAL BETWEEN ONSET AND DEATH 2 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma, Rt Ovary					6 mo.
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1750					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Jan. 15, 58 to Feb. 23, 1958 and last saw her alive on Feb. 23, 1958 Death occurred at 10:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) [Signature] M.D.			22b. ADDRESS 430 South Ave		22c. DATE SIGNED 2/24/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. NAME OF CEMETERY OR CREMATORY Fairlawn Cemetery		23d. LOCATION (City, town, or county) (State) Weatherford, Texas	
24. FUNERAL DIRECTOR H.H. Lohmeyer		ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 2-25-58	
26. REGISTRAR'S SIGNATURE [Signature]					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. All diseases in Part I must be causally related.

MAR 3 1958

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 *D. H. McCann*

Licensed Embalmer No. *2727*
P. O. Address *Springfield 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.