

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002247
STATE FILE NUMBER

FILED JAN 26 1959 Registration District No. 245 Primary Registration District No. 3047 Registrar's No. 5

300
1-57

1. PLACE OF DEATH a. COUNTY Newton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Newton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Neosho		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Granby 0938 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sale Memorial		Length of stay in lb 2 Days	d. STREET ADDRESS (If outside, give location) Rural Route # 2 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ISAAC Middle MILTON Last WOLFE	4. DATE OF DEATH Month January Day 12 Year 1959
--	---

5. SEX Male <input type="checkbox"/>	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 6, 1881	9. AGE (In years last birthday) 77	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) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Tenn.	12. CITIZEN OF WHAT COUNTRY? USA
--	--	--	--

13a. FATHER'S NAME Sterling Wolfe	13b. MOTHER'S MAIDEN NAME Rachel Walker	14. NAME OF HUSBAND OR WIFE Mrs. Jennie 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. None	17. INFORMANT Mrs. Jennie Wolfe R#2, Granby, Mo.	Address
---	--	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum with metastasis DUE TO (b) Chronic Interstitial Nephritis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2-3 years unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Anuria with Uremia		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 Month, Day, Year a.m. p.m.	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 Oct 1957 to Jan 12th 1959 and last saw her alive on Jan 12 - 1959 Death occurred at 8:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Melvin P. Bowman M.D.	22b. ADDRESS Neosho Mo	22c. DATE SIGNED 1-20-59
--	----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REPO (Specify) BURIAL	23b. DATE Jan. 14, 1959	23c. NAME OF CEMETERY OR CREMATORY Hazel Green Cemetery	23d. LOCATION (City, town, or county) (State) Newton Co. Missouri
---	-----------------------------------	---	---

24. FUNERAL DIRECTOR Thompson Funeral Home, Neosho, Mo.	ADDRESS 1-20-59	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE Melvin P. Bowman M.D.
---	---------------------------	------------------------------	---

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

JUL 2 1979

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 *Llyde M. Dameron*

Licensed Embalmer No. *5065*

P. O. Address *Neosho 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.