

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018036

STATE FILE NUMBER 2079

FILED JUN 9 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2079

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>KANSAS City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>610 Indiana</b>		d. STREET ADDRESS (If outside, give location) <b>610 INDIANA</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle Last <b>Wolfe</b>			4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1959</b>		
5. SEX <b>0</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1891</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (City and state or country) <b>Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>James Wolfe</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>Eula Wolfe</b>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>491-09-5781</b>	17. INFORMANT <b>MRS. Eula Wolfe</b>	Address <b>610 Indiana</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary Artery Arteriosclerosis</b>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 _____ a.m. _____ Month, Day, Year _____	

20d. INJURY OCCURRED WHILE AT WORK <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 <b>St. John, Mo.</b>	COUNTY <b>Jackson</b>	STATE <b>Mo.</b>
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21. I attended the deceased from **Jan 1959** to **April 23 1959** and last saw him alive on **April 23 1959**  
Death occurred at **S.A.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>K. L. Shireman, M.D.</b> (Degree or title)	22b. ADDRESS <b>4606 St. John, Mo.</b>	22c. DATE SIGNED <b>4-25-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 27, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CAMERON Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>CAMERON Missouri</b>
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24. FUNERAL DIRECTOR <b>Muehlebach</b> ADDRESS <b>6800 Troost</b>	25. DATE RECD. BY LOCAL-REG. <b>4-25-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

K. L. Shireman

All diseases in Part I must be causally related.

300  
-57

4606



John D. Johnson  
BE-1-4191  
St. John.

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 

Licensed Embalmer No. 5097

P. O. Address K.C. 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.