

OCT 30 1930

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH James town  
County Monteau Registration District No. 574  
Township Linn Primary Registration District No. 5772a  
City (No. ....) St. .... Ward)

30562  
File No. 1930  
Registered No. 11

2. FULL NAME Bernie Clifton Howard Wolfe  
(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF X

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-30-1918

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
10 10 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. No.  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Orange County  
(STATE OR COUNTRY)

10. NAME OF FATHER Calvin Wolfe

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elizabeth Griffith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

14. INFORMANT Stebian Wolfe  
(Address)

15. FILED Sept 30 1930 Ellis G Raiker  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 to Sept 3 1930 that I last saw him alive on Sept 3 1930 and that death occurred, on the date stated above, at 3 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Perforation of bowel

CONTRIBUTORY (SECONDARY) Typhoid fever (duration) yrs. mos. ds. 12

(duration) yrs. mos. ds. 15

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Ellis G. Raiker M. D.

(Address) James town Mo

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Mount Zion Semetary Sept 3 1930

20. UNDERTAKER ADDRESS

Wm Fallright Sons James town Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

