JUL 24 1929

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

Do not use this space.

17623

1. PLACE OF DEATH
County Clay
Township Platte
City ..... (No. ..... St. ..... Ward)

Registration District No. 203
Primary Registration District No. 5281

File No. .....
Registered No. .....

2. FULL NAME James Wade

(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.

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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-23-1843

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	86	0	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) retired 20 yrs.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Clay Co Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Peyton Wade
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Betsy Wilhoit
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)

14. INFORMANT Ernest Wade
(Address) Kearney, Mo, R.F.D.

15. FILED 7/10 1929 E. C. Hill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-19-1929

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 19, 1929 that I last saw him alive on May 19, 1929 and that death occurred, on the date stated above, at 7 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
11B Influenza

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (SECONDARY) 11B

(duration) ..... yrs. ..... mos. ..... ds.

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) J. F. Pope, M. D.
, 19 (Address) Smithville Mo. R.F.D. 2

*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
Paradise, Mo.	5-20 1929
20. UNDERTAKER	ADDRESS
McComas Undt Co.	Smithville Mo.