

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.

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

Do not use this space.

1. PLACE OF DEATH

County Boone
Township Rockyfork
City (No.) St. Ward

Registration District No. 74
Primary Registration District No. 5113

File No. 36704
Registered No. 20
St. Ward

2. FULL NAME

(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 <u>m.</u>	4. COLOR OR RACE <u>w.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mollie Wade</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>10-28-1862</u>		
7. AGE	YEARS <u>73</u>	MONTHS <u>14</u>
	DAYS <u>09</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>✓</u>	
	10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation <u>✓</u>	
MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) <u>Missouri</u>	
	13. NAME <u>Abraham Wade</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>	
	15. MAIDEN NAME <u>Susan Dexton</u>	
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) <u>Missouri</u>	
	17. INFORMANT (ADDRESS) <u>Mollie Wade</u> <u>Brown, Sta Mo</u>	
BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY)	18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Dripping Springs</u>	
	DATE <u>10-7-36</u>	
19. UNDERTAKER (ADDRESS) <u>Partor, J. Co.</u> <u>Columbia Mo</u>		
20. FILED <u>10-9-1936</u> <u>Mrs. J. L. Lawrence</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 7th 193622. I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1936 to Oct 7th 1936I last saw him alive on Oct 7th 1936 Death is saidto have occurred on the date stated above, at 8:30 a.m.

The principal cause of death and related causes of importance were as follows:

tuberculosis & dependency

Date of onset

Other contributory causes of importance:

Name of operation none Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19.....

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? Yes

If so, specify

(Signed) J. A. Grainger, M. D.(Address) Columbia Mo

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