

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

1803
Do not use this space.

REC'D FEB 21 1939

1. PLACE OF DEATH
(a) County Callaway Registration District No. 104
(b) Township _____ Primary Registration District No. 3008 Registered No. 27
(c) City Fulton (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Brown Wade
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5/10 1884

7. AGE YEARS 54 MONTHS 8 DAYS 9 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

FATHER 13. NAME Giles Wade
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

MOTHER 15. MAIDEN NAME Melvuna E. Dulaney
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT Burzy Wade (ADDRESS) New Bloomfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Carmel DATE 1/21/1939

19. FUNERAL DIRECTOR (NAME) Ray A. Holt, (ADDRESS) New Bloomfield, Missouri.

20. FILED Jan. 20, 1939 R. N. Crewe Local Registrar.

MEDICAL CERTIFICATE OF DEATH 39

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/19/1939, 1939

22. I HEREBY CERTIFY, That I attended deceased from 12/31, 1938, to 1/19, 1939
I last saw him alive on 1/19, 1939 Death is said to have occurred on the date stated above, at 1:15 A.
The principal cause of death and related causes of importance were as follows:
Septicemia (organism unknown) with resulting acute hypotension and embolic infarction of the brain
Date of onset Nov. 1938

Other contributory causes of importance:
Secondary Anemia - 92% Pulmonary Edema 1/18/39

Name of operation home Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? no

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? no
If so, specify _____
(Signed) Henry Dunt, M. D.
(Address) Fulton, Mo.

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,

Ray A. Holt

or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Ray A. Holt

Licensed Embalmer No.

2605

P. O. Address.....

New Bloomfield

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 this body is not embalmed, above space should be left blank.