

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Homer Phillips Hospital
(d) Length of stay: In hospital or institution 29 hrs 40 mi
In this community 30 years

3. (a) PRINT FULL NAME Richard Wade
3. (b) If veteran, name war World War
3. (c) Social Security No. 489-015630

4. Sex MALE 5. Color or race Negro 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Redie Wade 6. (c) Age of husband or wife if alive 32 years
7. Birth date of deceased (Month) 10 (Day) 5 (Year) 1895

8. AGE: Years 45 Months 2 Days 25 If less than one day hr. min.

9. Birthplace Unknown
10. Usual occupation LABORER
11. Industry or business WALDE CHRISTY
12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. (e) Informant Redie Wade
(b) Address 4422 Maffitt Ave
17. (a) BURIAL (b) Date thereof 1-6-41
(c) Place: burial or cremation Jefferson Barracks
18. (a) Signature of funeral director Mary Wade
(b) Address 4202 Grimes Ave
19. (a) JAN 4 1941 (b) J. W. Johnson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St Louis
(d) Street No. 4422 Maffitt
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 1 year 1941 hour 7:05 minute A M.
21. I hereby certify that I attended the deceased from December 31, 1940, to January 1, 1941;
that I last saw him alive on January 1, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
Due to _____
Due to _____
Other conditions _____
Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____
23. Signature J. W. Johnson (M. D. or other) _____
Address 2601 N Whittier Date signed _____

Duration 2 wks
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....

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

Signed *S. J. Watson*
Licensed Embalmer No. *2698*
P. O. Address *2769 Chouteau*

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, fact should be so stated above.