

No. 2
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5-17-39
X 23697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7737

State File No. _____

FILED APR 2 1947

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 92

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirkville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Community Nursing Home # 1 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 years
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kirkville
(If outside city or town limits, write "RURAL")
(d) Street No. 508 S. 6th.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas H. Wade

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M D 5. Color or race W
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 14 1883
(Month) (Day) (Year)

8. AGE: Years 64 Months 1 Days 11
If less than one day
hr. min.

9. Birthplace Putnam Co. Missouri 1
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER {
12. Name Granville Wade
13. Birthplace Unknown Kentucky 1
(City, town, or county) (State or foreign country)
14. Maiden name Lillie McCollum
15. Birthplace Unknown Missouri 1
(City, town, or county) (State or foreign country)

16. (a) Informant W. B. Wade
(b) Address Kirkville, Missouri

17. (a) Burial (b) Date thereof. 3/27/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address Kirkville, Missouri

19. (a) 3-28-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch. day 25
year 1947 hour 6:55 minute DP: M.

21. I hereby certify that I attended the deceased from Feb 13, 1947 to March 25, 1947;
that I last saw him alive on March 25, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral palsy 2 day
Duration

Due to hemorrhage in medulla

Due to _____

Other conditions paralysis agitans
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy hemorrhage medulla
PHYSICIAN [Signature]
Underline the cause to which death should be charged statistically.

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? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature M. J. Guteschewski 2 DO
Address Kirkville, Mo. Date signed 3-28-47

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

RECEIVED
District Health Officer No. 1
District File Number 4-47-612
Date Filed APR - 1 1947

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 W. E. Ritz
Licensed Embalmer No. 24181
P. O. Address W. E. Ritz

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.