

FILED OCT 4 1947

Registration District No. **318**

Primary Registration District No. **1003**

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

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Mary's Infirmary  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 24 days  
(Specify whether  
 In this community 24 days  
years, months or days)

**3. (a) PRINT FULL NAME** GEORGE WADE

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 12 1873  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>74</u>	<u>7</u>	<u>15</u>	_____ hr. _____ min.

9. Birthplace Cato Ark.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired laborer

11. Industry or business Steel Plant

**MOTHER, FATHER**

12. Name Unknown  
 13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name Minnie Adams  
 15. Birthplace Unknown Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant Caroline Bennett

(b) Address 315 A Merridosia, Madison, Ill.

17. (a) Removal (b) Date thereof Sept 30 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Death home Ill

18. (c) Signature of funeral director J. F. Braxton

(b) Address 2205 No. Ave. Death home Ill

19. (a) SEP 30 1947 (b) J. F. Braxton  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Illinois (b) County Madison  
 (c) City or town Madison  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 713 Washington  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 27  
 year 1947 hour 10 minute XX A M.

21. I hereby certify that I attended the deceased from 9/21  
 \_\_\_\_\_, 19\_\_\_\_, to 9/27/47, 19\_\_\_\_  
 that I last saw him alive on 9/22/1947, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral aneurysm  
occult

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: \_\_\_\_\_  
 Of operations: \_\_\_\_\_  
 Of autopsy: \_\_\_\_\_

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)  
 (c) Means of injury \_\_\_\_\_

23. Signature E. F. Warden (M. D. or other) MD  
 Address 934 N. 2nd St Date signed 9/29

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.....

*Thomas M. Robson*....., Registered Apprentice No. *492*  
working under my personal supervision.

Signed *Lyda Hughes*.....  
Licensed Embalmer No. *2938*  
P. O. Address. *St Louis 2120*

**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.**