

FILED SEP 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32293

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 184

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, Marshall township</u>	
c. LENGTH OF STAY (in this place) <u>14 days</u>		d. STREET ADDRESS (If rural, give location) <u>3 miles east of Marshall</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Fitzgibbon Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Walter</u>	b. (Middle) <u>Thomas</u>	c. (Last) <u>Wade</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 18th, 1950</u>
-------------------------------------	--------------------------	---------------------------	-----------------------	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 12, 1874</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
--------------------	-------------------------------	---	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	11. BIRTHPLACE (State or foreign country) <u>Clark Co. Kentucky /</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	---	--

13a. FATHER'S NAME <u>Martin Luther Wade</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Moore</u>	14. NAME OF HUSBAND OR WIFE <u>Rosa Sandidge Wade</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Walter Wade, Marshall, Mo. R # 4.</u>
---	-------------------------------------	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>9 mos. 24.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage -</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <u>High blood pressure -</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pulmonary Edema -</u>		331X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from Sept. 3, 1950, to Sept. 18, 1950, that I last saw the deceased alive on Sept. 19, 1950, and that death occurred at 11:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C. L. Lawless M.D.</u>	23b. ADDRESS <u>Marshall Mo.</u>	23c. DATE SIGNED <u>9-20-50</u>
--	----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept. 21, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Marshall, Missouri</u>
---	---------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>Sept. 20, 1950</u>	REGISTRAR'S SIGNATURE <u>Lidway T. Gray</u>	385	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>CAMPBELL-LEWIS, MARSHALL-MO.</u>
--	---	-----	--

(Licensed Embalmer's Statement on Reverse Side)

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

177
0

RECEIVED

9-25-50

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 9-25-50

VS
AUG 4 1950

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

James H. Lewis

Signed.....
Student Embalmer

Licensed Embalmer No. 4709

P. O. Address Muskogee, Mo

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.