

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18703

State File No. 4315
Registrar's No.

FILED MAY 17 1951

BIRTH NO. 26173-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Marys Infirmary		d. STREET ADDRESS (If rural, give location) 3528hanton 0	
3. NAME OF DECEASED a. (First) Vernon b. (Middle) c. (Last) Ray Wade			4. DATE OF DEATH (Month) (Day) (Year) 4-2-51
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 3-29-51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St Louis Mo 0
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Dorothy Wade	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dorothy Wade 2528hanton
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? 776X	
22. I hereby certify that I attended the deceased from 3-29, 1951, to 4-2, 1951, that I last saw the deceased alive on 4-2-51, 19, and that death occurred at 4:30 a. m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) (Signature)		23b. ADDRESS 1536 Papine	23c. DATE SIGNED 4/2/51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis 10, Missouri service Inc.
DATE REC'D BY LOCAL REG. MAY 8 1951	REGISTRAR'S SIGNATURE J B Foster	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary St. Louis 10, Missouri	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD 0

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.....

....., **Student Embalmer No.**

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.