

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8954

State File No.

FILED MAR 21 1952

BIRTH NO. _____ REG. DIST. NO. 383 PRIMARY REG. DIST. NO. 5655 Registrar's No. 35

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Lawrence | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mt. Vernon | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 350 Aldridge, Kirkwood | |
| c. LENGTH OF STAY (in this place) 674 days | | d. STREET ADDRESS (If rural, give location) 350 Aldridge | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. state Sanatorium | | | |

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|---|------------|-------------|-----------------------|---------------------------------|----------------------|
| 3. NAME OF DECEASED (Type or Print) Mary | a. (First) | b. (Middle) | c. (Last) Wade | 4. DATE OF DEATH 3-15-52 | (Month) (Day) (Year) |
|---|------------|-------------|-----------------------|---------------------------------|----------------------|

| | | | | | | | | | |
|----------------------|---|---------------------------------|---|---------------------------------|---|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX Female | 3 | 6. COLOR OR RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 5-16-71 | 9. AGE (In years last birthday) 80 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 YEAR Hours | IF UNDER 1 YEAR Min. |
|----------------------|---|---------------------------------|---|---------------------------------|---|------------------------|----------------------|-----------------------|----------------------|

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|--|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Mississippi | 12. CITIZEN OF WHAT COUNTRY? USA |
|--|-----------------------------------|--|---|

| | | |
|---|---|-----------------------------|
| 13a. FATHER'S NAME Simon Whitfield | 13b. MOTHER'S MAIDEN NAME Vernia Whitfield | 14. NAME OF HUSBAND OR WIFE |
|---|---|-----------------------------|

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|--|--|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT'S SIGNATURE OR NAME Ruby Wilson Peck, Mt. Vernon, Mo. | ADDRESS |
|--|--|--|---------|

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH abt. 3 yrs. |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis | | |
| | 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? 002X | 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) |
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| | | |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month), (Day), (Year) (Hour) (Min.) | 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 **5-9-50**, 19__, to **3-15-**, 19 **52**, that I last saw the deceased alive on **3-15-**, 19 **52**, and that death occurred at **1:10 p.m.**, from the causes and on the date stated above.

| | | | |
|---|----------------------------|-------------------------------------|---------------------------------|
| 23a. SIGNATURE C. G. Bunker M.D. | (Degree or title) 0 | 23b. ADDRESS Mt. Vernon, Mo. | 23c. DATE SIGNED 3-15-52 |
|---|----------------------------|-------------------------------------|---------------------------------|

| | | | |
|---|------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Mar 21 1952 | 24c. NAME OF CEMETERY OR CREMATORY Father Dickson | 24d. LOCATION (City, town, or county) (State) St. Louis County Mo. |
|---|------------------------------|--|---|

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|---|---|--|-----------------------------------|
| DATE REC'D BY LOCAL REG. 3-19-52 | REGISTRAR'S SIGNATURE Cecil Handrick | 25. FUNERAL DIRECTOR'S SIGNATURE John H. Hemphill | ADDRESS 408 E. Fillmore Av |
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(Licensed Embalmers' Statement on Reverse Side)

Kirkwood St. Mo.

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

550

APR 11 1952

STATEMENT BY LICENSED EMBALMER

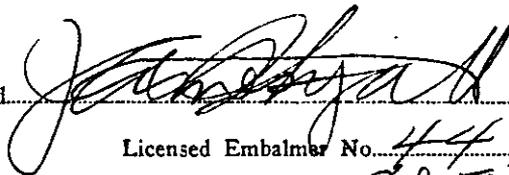
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 4441

P. O. Address 408 S Fillmore

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.