

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36961

State File No. ....

NOV 12 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9428**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY	
b. CITY OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3228a Pennselvania</b>		d. STREET ADDRESS <b>3228a Pennselvania</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Sophia</b> b. (Middle) c. (Last) <b>Wade</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>10 10 52</b>	
--	--	---	--

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <b>married</b> (Specify)	8. DATE OF BIRTH <b>11-8-1877</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
----------------------	-------------------------------	--	-----------------------------------	---	------------------------	------------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hwk</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>St. Louis Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
--	-----------------------------------	---	--

13a. FATHER'S NAME <b>Michael Diebling</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Danner</b>	14. NAME OF HUSBAND OR WIFE <b>Walter Wade</b>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Walter Wade</b>	ADDRESS <b>3228a Pennselvania</b>
--	-------------------------	--	-----------------------------------

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 <b>1 yr</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arterio Sclerotic Heart di</b>		
	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. <b>Hypertension</b>		<b>5 yr</b>	

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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4200</b>
---	--	--

22. I hereby certify that I attended the deceased from **1944**, 19, to **10/10**, 19**52**, that I last saw the deceased alive on **11/9**, 19**52**, and that death occurred at **11 P** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Dr. Acoster MO</b> (Degree or title)	23b. ADDRESS <b>5600 S Compton</b>	23c. DATE SIGNED <b>10/13/52</b>
--	------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>10-14-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>SS Peter &amp; Paul</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>
---	---------------------------	---	---

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>OCT 14 1952</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Moydell Funeral Home</b>	ADDRESS <b>1926 Allen</b>
--	--	---------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

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 me

working under my personal supervision.

Student Embalmer No. ....

Signed John A. Traumann

Signed.....  
Student Embalmer

Licensed Embalmer No. 4533

P. O. Address St. Louis 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.