

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39617**
Registrar's No. **2591**

FILED NOV 22 1954

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY OR TOWN Richmond Mo		c. CITY OR TOWN Clayton Mo	
c. LENGTH OF STAY (in this place) 2 Days		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hosp		STREET ADDRESS (In rural, give location) 17 Crestwood Dr	

3. NAME OF DECEASED (Type or Print) **MARGARET ELIZABETH WADE**

a. (First) _____ b. (Middle) _____ c. (Last) _____

4. DATE OF DEATH (Month) (Day) (Year) **Nov 5 1954**

5. SEX **F** 6. COLOR OR RACE **W** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Single** 8. DATE OF BIRTH **Jan 19-1930**

9. AGE (In years last birthday) **24** IF UNDER 1 YEAR: Months **9** Days **17** IF UNDER 1 HRs. Hours _____ Mins. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Historian**

10b. KIND OF BUSINESS OR INDUSTRY **Self Employed**

11. BIRTHPLACE (City and State or Foreign Country) **Richmond Mo**

12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **James P Wade** 13b. MOTHER'S MAIDEN NAME **Mary Phillips James** 14. NAME OF HUSBAND OR WIFE **NONE**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes, give year or dates of service) **None**

16. SOCIAL SECURITY NO. **492-348247**

17. INFORMANT'S SIGNATURE OR NAME **James P Wade** ADDRESS **17 Crestwood Dr**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Respiratory failure**

ANTECEDENT CAUSES DUE TO (b) **Polio myelitis**

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS **Probable acute hep inf.**

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH **48 hrs**

15 mos

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION **88D3** 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov 3, 1954** to **Nov 5, 1954**, that I last saw the deceased alive on **11/5**, 1954, and that death occurred at **7:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE **Ka Kusaga** (Degree or title) _____ 23b. ADDRESS **3720 Washington** 23c. DATE SIGNED **11/8/54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **Nov 9-1954** 24c. NAME OF CEMETERY OR CREMATORY **Resurrection Cem St. Louis Mo** 24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. **11/8/54** REGISTRAR'S SIGNATURE **Hebech Lambert** 25. FUNERAL DIRECTOR'S SIGNATURE **H. Docke** ADDRESS **6536 Clayton Rd**

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~~....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Elmo R. Sadwell*.....

Licensed Embalmer No. *4257*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.