

FILED APR 2 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11566****318**PRIMARY REG. DIST. NO. **1003**Registrar's No. **2617**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2617				
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. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) 5836 Cates Ave.				20510		
3. NAME OF DECEASED (Type or Print) a. (First) Jesse			b. (Middle) L.		c. (Last) Wade		4. DATE OF DEATH (Month) (Day) (Year) March 12, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower		8. DATE OF BIRTH Aug. 2, 1881		9. AGE (In years last birthday) 74 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 2 HRS.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Wadesville, Ind.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME William Wade			13b. MOTHER'S MAIDEN NAME Josephine Taylor			14. NAME OF HUSBAND OR WIFE Evaline Wade				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 496-36-2638		17. INFORMANT'S SIGNATURE OR NAME Mrs. Walter Vowels			ADDRESS 5836 Cates Ave.			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 4 days 1 yr.		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 420.0						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) _____		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 March 9, 1956 , to March 12 19 56 that I last saw the deceased alive on March 12, 19 56 , and that death occurred at 8:15 A. M. , from the causes and on the date stated above.										
23a. SIGNATURE <i>Carl Smith M.D.</i> (Degree or title) M. D.				23b. ADDRESS BARNES HOSPITAL			23c. DATE SIGNED 3/12/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-14-56		24c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		24d. LOCATION (City, town, or county) (State) Ridgeway Twp., Ill.				
DATE REC'D BY LOCAL REG. MAR 13 1956		REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>			25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe				ADDRESS 4700 Washington Blvd	

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

Student.....
Signature of Student Embalmer

Signed *Robert M. Murray*

Licensed Embalmer No. *3*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.