

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33713

State File No. ....

FILED OCT 22 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 943

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

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>MISSOURI</u> b. COUNTY <u>WRIGHT</u>	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>SPRINGFIELD</u>	c. LENGTH OF STAY (in this place) township) _____	c. CITY OR TOWN <u>MTN GROVE</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BAPTIST HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>331 W. NORTH ST.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>TOM</u>	b. (Middle) _____	c. (Last) <u>WADE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 15, 1956</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV 25, 1877</u>	9. AGE (In years) (Last Month) (Days) <u>78 10 20</u>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOWNSHIP</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>ASSESSOR</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>WRIGHT CO. MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		

13a. FATHER'S NAME <u>D. H. WADE</u>	13b. MOTHER'S MAIDEN NAME <u>MARY PAUL</u>	14. NAME OF HUSBAND OR WIFE <u>EMMA WADE</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT'S SIGNATURE OR NAME <u>EMMA WADE WITH GROW</u>	ADDRESS <u>MTN GROVE MO</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		<u>21</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>with quadriplegia</u> DUE TO (c) <u>Gen. Arteriosclerosis</u>		
	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 checked="" type="checkbox"/>
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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) <u>332X</u>
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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? _____
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22. I hereby certify that I attended the deceased from 9/23, 1956, to 10/15, 1956, that I last saw the deceased alive on 10/15, 1956, and that death occurred at 1:35 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. Callaway MD</u> (Degree or title)	23b. ADDRESS <u>Springfield MO</u>	23c. DATE SIGNED <u>10/16/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>10-16-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hickcrest</u>	24d. LOCATION (City, town, or county) (State) <u>MTN GROVE, MO</u>
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DATE REC'D BY LOCAL REG. <u>10-17-56</u>	REGISTRAR'S SIGNATURE <u>Frank Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Geoff. Wills WITH GROW</u>	ADDRESS <u>MO</u>
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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 *Frank Grable*.....

Licensed Embalmer No. *4140*.....

P. O. Address *Salem, Mass*.....

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.