

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 44974  
Registrar's No. 2972

BIRTH NO. _____		REG. DIST. NO. <u>312</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>2972</u>							
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> subdivision <u>109</u>									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: <u>Koch Mo.</u>		c. LENGTH OF STAY (in this place) <u>6 days</u>		c. CITY OR TOWN <u>St. Louis 109</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>Koch Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>3530 Paris</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>Levi</u>			b. (Middle) <u>/</u>		c. (Last) <u>Wade</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12-12-56</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>12-15-09</u>		9. AGE (In years last birthday) <u>46</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 Hrs. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waiter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>waiter</u>				11. BIRTHPLACE (City and State or Foreign Country) <u>Arkansas</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Wade</u>				13b. MOTHER'S MAIDEN NAME <u>Dora ?</u>				14. NAME OF HUSBAND OR WIFE <u>Beatrice Fletcher Wade</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>448-03-1925</u>				17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records of Robert Koch Hospital</u>					
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Resection of right upper lobe of right lung</u> 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 <u>18 hours</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Hemorrhage from right upper lung</u>								20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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 <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 <u>12-6-</u> , 19 <u>56</u> , to <u>12-12-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-12-</u> , 19 <u>56</u> , and that death occurred at <u>11:15 p. m.</u> , from the causes and on the date stated above.													
23a. SIGNATURE (Degree or title) <u>Arul R. Brogan M.D.</u>						23b. ADDRESS <u>Robert Koch Hospital</u>				23c. DATE SIGNED <u>12/13/56</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>12/18/56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>				24d. LOCATION (City, town, or county) (State) <u>HATI, MO</u>					
DATE REC'D BY LOCAL REG. <u>12-16-56</u>		REGISTRAR'S SIGNATURE <u>Herbert B. Donk</u>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>G W A D E GRANBERRY 4202 FINNEY</u>							

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..... *Melvin E. Green*

Licensed Embalmer No. *4428*

P. O. Address *St Louis - 1*

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.