

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12530**

S. No. 300

LV. 10.48

FILED MAY 6 - 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 72 PRIMARY REG. DIST. NO. 5289 Registrar's No. 37

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>CLAY</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MO.</u> b. COUNTY <u>CLAY</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>RURAL GALLATIN</u> | c. LENGTH OF STAY (in this place) <u>30 YRS</u> | c. CITY OR TOWN <u>Liberty</u>  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1/2 mi North Ford PLANT</u>                 |   | e. STREET ADDRESS (If rural, give location) <u>RT4 1/2 mi North Ford PLANT</u>  |   |

|   |             |                       |  |
|---|-------------|-----------------------|--|
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>OSCAR</u> | b. (Middle) | c. (Last) <u>Wade</u> | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>APRIL 26 1957</u> |
|---|-------------|-----------------------|--|

|                    |                               |   |                                      |   |                             |                             |
|--------------------|-------------------------------|---|--------------------------------------|---|-----------------------------|-----------------------------|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>JAN 14, 1882</u> | 9. AGE (In years last birthday) <u>75</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>Real Estate Agent North Kansas City</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <u>Paradise, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> |
|--|-----------------------------------|---|---|

|                                      |   |  |
|--------------------------------------|---|--|
| 13a. FATHER'S NAME <u>L. B. Wade</u> | 13b. MOTHER'S MAIDEN NAME <u>ANNA M YATES</u> | 14. NAME OF HUSBAND OR WIFE <u>Sallie Wade</u> |
|--------------------------------------|---|--|

|  |                         |  |
|--|-------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. Osalee TAYLOR RT4 Liberty Mo</u> |
|--|-------------------------|--|

|   |   |  |   |
|---|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Artery</u>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 weeks</u><br><u>10 years</u><br><u>2 years</u> |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Congestive Heart failure</u> |  |   |
|   | DUE TO (c) <u>Hypertensive C-V disease</u>  |  |   |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral Hemorrhage</u>  |   |  |   |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>443X</u> |
|------------------------|----------------------------------|--|

|  |  |   |
|--|--|---|
| 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) m. | 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 3/22, 1957, to 4/26, 1957 that I last saw the deceased alive on 4/26, 1957 and that death occurred at 3:30 a.m., from the causes and on the date stated above.

|   |  |                                 |
|---|--|---------------------------------|
| 23a. SIGNATURE <u>James E. McFarmin, M.D.</u> (Degree or title) | 23b. ADDRESS <u>4030 Moor 15014 Mo</u> | 23c. DATE SIGNED <u>4/26/57</u> |
|---|--|---------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>4-28-57</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>PLATTE CITY CEMETERY PLATTE CITY, MO</u> | 24d. LOCATION (City, town, or county) (State) |
|---|--------------------------|--|---|

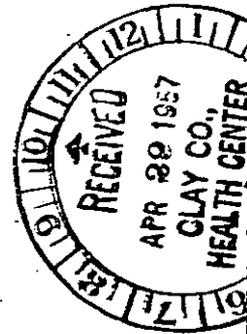
|   |  |  |
|---|--|--|
| DATE REC'D BY LOCAL REG. <u>4-27-57</u> | REGISTRAR'S SIGNATURE <u>Marquerita Ludwig</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D.W. Newcomer's Sons NORTH KANSAS CITY</u> |
|---|--|--|

(Licensed Embalmer's Statement on Reverse Side)

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

494

JUL 14 1959



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 *Glenn H. Hill*.....

Licensed Embalmer No. *4586*.....

P. O. Address *K.C. 16. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.