

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004461

FILED VS JAN 19 1961

STATE FILE NUMBER

Registration District No. 375 Primary Registration District No. 6284 Registrar's No. 28

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>WRIGHT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MANES</u>		Length of stay in 1b		c. CITY OR TOWN <u>MANES</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Manes, Mo.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES HENRY WADE</u>				4. DATE OF DEATH Month Day Year <u>Jan. 5 1961</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2-1898</u>		9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer, retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>				11. BIRTHPLACE (City and state or country) <u>MANES, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>					
13a. FATHER'S NAME <u>John R. Wade</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah Beckham</u>				14. NAME OF HUSBAND OR WIFE <u>Melbissa 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>None</u>		17. INFORMANT Address <u>Melbissa Wade Manes, Mo.</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, stomach</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2 hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				20f. CITY, TOWN, OR LOCATION				COUNTY				STATE			
21. I attended the deceased from <u>June 14 59</u> to <u>Jan 5 1961</u> and last saw her on <u>Jan 4 1961</u> Death occurred at <u>6:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>Del Cannon M.D.</u>						22b. ADDRESS <u>Mountain Pine Mo.</u>						22c. DATE SIGNED <u>1-9-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)							
<u>Burial</u>		<u>1-7-1961</u>		<u>Embree Cemetery Manes, Wright, Mo.</u>				<u>Mo.</u>							
24. FUNERAL DIRECTOR <u>Ewell C. CRAIG Mtn. Grove, Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>1-16-61</u>		26. REGISTRAR'S SIGNATURE <u>Bonnie J. Jones Ruth Carter</u>							

Received
1-16-61

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 Lowell C. Gray

Licensed Embalmer No. 1766

P. O. Address The Groves, N.Y.

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.