

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 4714

1 PLACE OF DEATH

County Dickson
Township Windsor
or Maysville
Village
or
City

Registration District No. 259 File No.
Primary Registration District No. 4158 Registered No. 3
(NO. St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Burrell Wade

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE wh. 5 SINGLE MARRIED WIDOWED OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH June 3 1898
(Month) (Day) (Year)

7 AGE 84 yrs. 8 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Retired Merchant
(b) General nature of industry business, or establishment in which employed (or employer) Furniture

9 BIRTHPLACE (City or town, State or foreign country) Va.

PARENTS
10 NAME OF FATHER Owen Wade
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown
12 MAIDEN NAME OF MOTHER Louisa Phelan
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wade T. Hawkey
(Address) Maysville, Mo.

15 Filed 8-9-1918 W. J. Clark
Registrar

5 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 4th 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 1 1918 to Feb 1 1918,
that I last saw him alive on Feb 23 1918,
and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis
Chronic interstitial Cystitis
1310 (Duration) 170 yrs. mos. ds.
10 (Duration) yrs. mos. ds.

CONTRIBUTORY Scrubty
(Secondary) (Duration) yrs. mos. ds.
(Signed) W. J. Clark
Feb 24 1918 (Address) Maysville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Maysville Mo DATE OF BURIAL 1918

20 UNDERTAKER W. J. Pichee ADDRESS Maysville

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Graemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Maack
Township _____
or _____
Village _____
or _____
City Manysville (NO. _____ St. _____ Ward _____)

REGISTRARS SHALL NOT RECEIVE
A FEE FOR CERTIFICATES UNTIL THEY
ARE COMPLETED AS PRESCRIBED BY
LAW

Registration District No. 259 File No. _____

Primary Registration District No. H-58 Registered No. _____

(If death occurred in a
hospital or institution,
give its NAME instead
of street and number.)

2 FULL NAME William B. Wade

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) W

6 DATE OF BIRTH _____ (Month) _____ (Day) 1 _____ (Year)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day _____ hrs. or _____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9 BIRTHPLACE
(City or town, State or foreign country) _____

PARENTS
10 NAME OF FATHER _____
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
12 MAIDEN NAME OF MOTHER _____
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15 Filed 3-9-1918 W. J. Clark Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb - 23 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ 191____ to _____ 191____
that I last saw h. _____ alive on _____ 191____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____ 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospital, Institutions, Transients, or Recent Residents)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Higgersville Mo DATE OF BURIAL Feb 25 1918

20 UNDERTAKER W. L. Pilebur ADDRESS Manysville Mo

Original file, date _____, 19____

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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