

JAN 23 1929

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

Do not use this space.

36600

1. PLACE OF DEATH
 County Missouri Registration District No. 317
 Township Pond Creek Primary Registration District No. 5437
 City Republic Mo Route 1 St. _____ Ward _____

2. FULL NAME Dardena A Wade
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. B. Wade (deceased)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 16 1851

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
96 11 6

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housekeeping
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer her own Employer

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Ark.

10. NAME OF FATHER Leroy C. Denny

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Martha Hosh

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

14. INFORMANT B. B. Wade
 (Address) Living Free

15. FILED 11/23 28 J. G. Graue
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) November 22 1928

17. I HEREBY CERTIFY, That I attended deceased from July 1 1928, to November 22 1928 that I last saw him alive on November 22 1928, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hodgkins Disease
72-65B
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) nothing
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH at her home

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Signs
 (Signed) E. L. Beal, M. D.
 _____, 19 _____ (Address) Republic Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wades Chapel Cemetery DATE OF BURIAL 11/24 1928

20. UNDERTAKER R. E. Larrison ADDRESS Republic Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

