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

Do not use this space.
10877
10927
1433

1. PLACE OF DEATH
County Jackson — Registration District No. ..... — File No. .....
Township Kaw — Primary Registration District No. ..... — Registered No. .....
City Kansas City (No. 3209 Hancock St. ..... Ward)

2. FULL NAME John Wm. Wade
(a) Residence. No. 3209 Hancock 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: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edith Alice Wade

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 30 - 1850

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| 78 | 3 | 23 | |

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bloomington Iowa

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Frank L. Wade
(Address) 3209 Hancock Court

15. FILED 3/23, 1929 M. M. Cinna Asst REGISTRAR

**MEDICAL CERTIFICATE OF DEATH** 3 Saturday

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 23 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 1:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia
1 Ab
1 Ab
1 Ab
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fall in his home + Injury to rt side of head (duration) ..... yrs. ..... mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? yes history + Inspection
WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) Shirley M. Hall, M.D.
3/23, 1929 (Address) Deputy Coroner

*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: Plymouth Tel.
DATE OF BURIAL: 3-26-1929
20. UNDERTAKER: Eylar Funeral Home
ADDRESS: 1800 Linwood

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD