

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

Do not use this space.

42243

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

No. **4328 Fairfax**

File No.

Registered No. **11961**

St. Ward)

2. FULL NAME

(a) Residence. No. **4328 Fairfax** St. **11** Ward.

(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 OF RACE **Caucasian** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mattie Wade**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 30 - 1879**

7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min. **50 4 4**

8. OCCUPATION OF DECEASED **Porter**

- (a) Trade, profession, or particular kind of work
- (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) **Macon Tenn**

10. NAME OF FATHER **Giles Wade**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Macon Tenn**

12. MAIDEN NAME OF MOTHER **Tobitha Bidean**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Macon Tenn**

14. INFORMANT (Address) **Mattie Wade 4328 Fairfax**

15. FILED **DEC 9 1929** **Max C. Tomlin** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **12-4-1929**

17. I HEREBY CERTIFY, That I attended deceased from **Dec 1st**, 19**29** to **Dec 4**, 19**29** that I last saw him live on **Dec 4**, 19**29** and that death occurred, on the date stated above, at **8:30 a.m.**

THE CAUSE OF DEATH WAS AS FOLLOWS **10 pleurisy**

18. WHERE WAS DISEASE CONTRACTED **Obstruction of bile duct** (duration) yrs. mos. ds. **5** ds.

18. WHERE WAS DISEASE CONTRACTED **Wuert** IF NOT AT PLACE OF DEATH.....

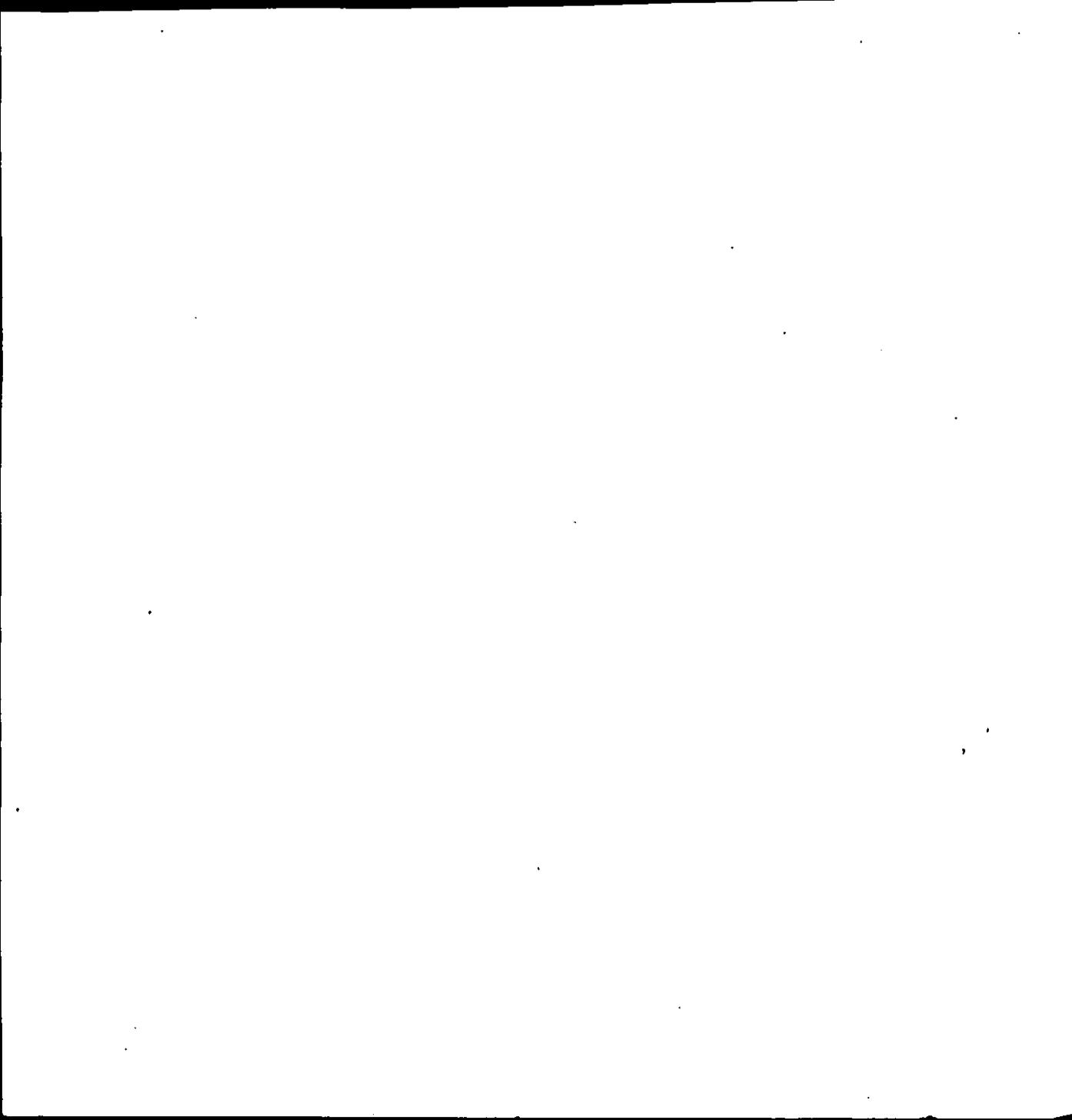
DID AN OPERATION PRECEDE DEATH? **No** DATE OF..... WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **Plural** (Signed) **J. E. Moore** M. D.

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. **got 12/4/29**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Wilmington Park** DATE OF BURIAL **12-8-29**

20. UNDERTAKER **W. S. Moore** ADDRESS **4282**



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 791 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 11761
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME William 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 m 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (c) Name of employer _____

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

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT _____ (Address) _____

15. FILED 116-0-19155 Max C. Starker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/4 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) Obstruction of bile duct due to gall stones (duration) _____ yrs. _____ mos. _____ ds.
Information given over phone by Dr. B. C. Moore, M.D. 2-6-30
 18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) 1213 _____, M. D.

_____, 19____ (Address)

*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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

S-42243