

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

Do not use this space.

11170

1. PLACE OF DEATH

County..... Registration District No. 70
Township..... Primary Registration District No. 2
City St. Louis, Mo. (No. City Hospital #2)

File No.
Registered No. 3765
St. Ward)

2. FULL NAME

Barbara Wade
(a) Residence, No. 1144 Ward Center St. Ward. 11
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>3-6-32</u>		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, hrs. or min.
		<u>10</u>

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	<u>nil</u>
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo. (STATE OR COUNTRY) 1

13. NAME Sarah Wade

14. BIRTHPLACE (CITY OR TOWN) Miss. (STATE OR COUNTRY) 2

15. MAIDEN NAME Millie Behm

16. BIRTHPLACE (CITY OR TOWN) Miss. (STATE OR COUNTRY)

17. INFORMANT A. D. ... (ADDRESS) City Hospital #2

18. BURIAL, CREMATION, OR REMOVAL
PLACE POTTER DATE 4-21-1932

19. UNDERTAKER ... (ADDRESS)

20. FILED APR 18 1932 ... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-16-1932

22. I HEREBY CERTIFY, That I attended deceased from 3-6-1932 to 3-16-1932

I last saw h. live alive on 3-16-1932 Death is said to have occurred on the date stated above, at 8:20 m.

The principal cause of death and related causes of importance were as follows:

116A
Stricture of Esophagus
Congenital
Other contributory causes of importance:
116 (1)

Name of operation..... Date of.....
What test confirmed diagnosis? ... Was there an autopsy? 1

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) ..., M. D.
(Address) City Hospital #2

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

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.

