

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

Do not use this space.

10899

1. PLACE OF BIRTH

County *St. Louis*
Township *St. Ferdinand*
City *St. Louis*

Registration District No. *784*
Primary Registration District No. *6030*

File No. _____
Registered No. _____
St. _____ Ward

2. FULL NAME

(a) Residence No. *St. Louis Training School* Ward

Length of residence in city or town where death occurred *1 yrs. 9 mos. 17 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) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 29, 1922*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10 7 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Paducah*
(STATE OR COUNTRY) *Kentucky*

10. NAME OF FATHER *Len Wade*

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

12. MAIDEN NAME OF MOTHER *Lovie Chapman*

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

14. INFORMANT *St. Louis Training School Records*
(Address)

15. FILED *March 30th 1933* *Emma J. Harris* REGISTRAR
4-7

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 28 1933*

17. I HEREBY CERTIFY, That I attended deceased from *June 11, 1931*, to *March 28, 1933* that I last saw him alive on *March 28, 1933*, and that death occurred, on the date stated above, at *5:35 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis due to Right Lateral Sinus Thrombosis following Acute Medulla

CONTRIBUTORY (SECONDARY) *Imbecility* (duration) yrs. mos. ds. *36*
Life (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical*
(Signed) *L. A. Mierch*, M. D.

Mar. 28 1933 (Address) *St. Louis Training School St. Louis, 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 *St. Matthews Cem* DATE OF BURIAL *3-30 1933*

20. UNDERTAKER *Feigenheim Bros.* ADDRESS *2625 Chesapeake St.*

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.

