

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.

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

Do not use this space.

MAY 2 3 1935

791  
1003

14807

**1. PLACE OF DEATH**

County..... Registration District No.....  
 Township..... Primary Registration District No.....  
 City St. Louis (No. Bethesda Hospital) St. 3658 Ward.....

**2. FULL NAME**

Charles L. Bade  
 (a) Residence, No. 2313 Indiana Ave. St. 23 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Nil</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 5-1926</u>		
7. AGE YEARS <u>8</u>	MONTHS <u>4</u>	DAYS <u>17</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>School Boy</u>		If LESS than 1 day, .....hrs. or .....min.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>Charles School</u>		11. Total time (years) spent in this occupation
10. Date deceased last worked at this occupation (month and year)		<u>Sumbo</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
13. NAME <u>Henry Bade</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis Mo</u>		
15. MAIDEN NAME <u>Lena Estes</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Guzman Mo</u>		
17. INFORMANT (ADDRESS) <u>Henry Bade</u> <u>2313 Indiana Ave</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Matthews</u> DATE <u>Apr 24</u> 19 <u>35</u>		
19. UNDERTAKER (ADDRESS) <u>Wacker's Undertaker</u> <u>2331 Broadway</u> <u>APR 23 1935</u>		
20. FILED <u>Bledsoe</u> Registrar		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 22 1935

22. I HEREBY CERTIFY, That I attended deceased from April 9 1935, to April 22 1935  
 I last saw h. alive on April 21 1935 Death is said to have occurred on the date stated above, at 7:15 a.m.  
 The principal cause of death and related causes of importance were as follows:  
non epidemic  
Streptococcus meningitis  
 Date of onset 4/13/35

Other contributory causes of importance:  
Acute Rhinitis 2

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

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 Yes  
 (Signed) L. W. Riber M. D.  
 (Address) 2840 California

