

DECEMBER 13 1939

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

6582  
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 378  
(b) Township \_\_\_\_\_ Primary Registration District No. 2001 Registered No. 177  
(c) City SPRINGFIELD (d) Street No. Springfield Baptist Hospital St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Forest, Wade Travis  
(a) Residence, No. Willow Springs St. 1 Willow Springs Mo.  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-27, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 2-27, 1939, to 2-27, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 27, 1939  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 0 0 0 0 0 0

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 5:10 p.m.  
The principal cause of death and related causes of importance were as follows:

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

Still-born Full-term 8\*12g  
Protracted labor from contracted Pelvis  
Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield, Mo.

Other contributory causes of importance: \_\_\_\_\_

FATHER 13. NAME Charles Travis Wade

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Clinical Was there an autopsy? No.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Willow Springs Mo.

MOTHER 15. MAIDEN NAME Mary Wade

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.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mt. Grove, Mo.

17. INFORMANT (ADDRESS) Charles & Mary Wade Travis Mt. Grove, Mo.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Grove Mo. DATE Feb. 28, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Russell Barber Mt. Grove, Mo.

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) R. M. White, M. D.  
(Address) Springfield Mo.

20. FILED Feb 27 1939 Chas. A. George Mo.  
Local Registrar

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.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**