

REC'D JUN 12 1939

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH
17250
Do not use this space.

1. PLACE OF DEATH

 (a) County.....
 (b) Township.....
 or
 (c) City St. Louis (d) Street No. Homer Phillips Hospital St.
 (e) Length of residence in city or town where death occurred 20 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
Registration District No. 791Primary Registration District No. 1008Registered No. 47842. PRINT FULL NAME Arthur Wade
 (a) Residence, No. 2320 Wash St. 21 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX M 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 16, 1889
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
49 5 7

 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 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
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee13. NAME Sam Wade14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee15. MAIDEN NAME Matilda ?16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee17. INFORMANT (ADDRESS) Evelyn Hilliard
2601 N Whittier18. BURIAL, CREMATION, OR REMOVAL PLACES Father Dickson DATE 5-27 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) Watson and Son
2769 e houston20. FILED MAY 26 1939 J. B. ... Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23, 1939 19
 22. I HEREBY CERTIFY, That I attended deceased from April 4, 1941 19 to May 23, 1939 19
 I last saw him alive on May 23, 1939 19 Death is said to have occurred on the date stated above, at 11:20 a.m. p.m.
 The principal cause of death and related causes of importance were as follows:

Malignancy of left shoulder with probable generalized metastasis

Date of onset

4/4/39

Other contributory causes of importance:

 Name of operation..... Date of.....
 What test confirmed diagnosis? clinical Was there an autopsy? no

 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 NO
 (Signed) H. J. Lyman, M. D.
 (Address) 2601 n whittier

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

17250
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
(b) Township..... Primary Registration District No. 1003
(c) City St. Louis (d) Street No. 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 Arthur Wade

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE c 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) mar

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.
49 5 7

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 9/15/39 J. B. Breda Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr 4 to Apr 23, 1939

I last saw him alive on 5-23, 1939. Death is said to have occurred on the date stated above, at 11-2 m.

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

Date of onset

Other contributory causes of importance:

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

(Signed) H. J. Leonard, M. D.

(Address)

SUPPLEMENTAL

1 X12241

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

WHILE FILLING IN WITH UNFADING INK--THIS IS A PERMANENT RECORD

