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.

DEC 1 AUG 11 1939

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

25290
Do not use this space.

1. PLACE OF DEATH
(a) County Cape Girardeau 2 Registration District No. 124
(b) Township 1 Primary Registration District No. 4070 Registered No. 28
(c) City Jackson (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 300 Carolyn Bernice Wade
(a) Residence, No. ..... St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: negro
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) Jan 27 - 1939
7. AGE: YEARS | MONTHS 6 | DAYS 25 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
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) Jackson Mo

FATHER
13. NAME Ellis Wade
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Mo

MOTHER
15. MAIDEN NAME Alberta Day
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pocahontas Mo.

17. INFORMANT (ADDRESS) Ellis Wade Jackson Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Russell 16 sight DATE July 23 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Macke-Wilson-Statler Jackson Mo

20. FILED 7-24 1939 D. G. Seibert Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-22 1939

22. I HEREBY CERTIFY, That I attended deceased from birth, 19..., to 7-22, 1939
I last saw her alive on 7-21, 1939 Death is said to have occurred on the date stated above, at 5a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Tuberculous meningitis	7-16-39
24	

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? No
If so, specify Acute tuberculosis in home
(Signed) [signature], M. D.
120 (Address) Jackson, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson Mo.

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

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