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 18 1939

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

40095
Do not use this space.

1. PLACE OF DEATH

(a) County Lafayette 2 Registration District No. 464

(b) Township Washington 1 Primary Registration District No. 5626 Registered No. 49

(c) City ..... (d) Street No. ..... St.

(e) Length of residence in city or town where death occurred 30 yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number) (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 3rd Molly 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: Fe
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: T.E. Wade

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan. 2, 1870

7. AGE: YEARS 69 MONTHS 10 DAYS 6 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: House wife
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): Casey Co., Kentucky

FATHER
13. NAME: W. H. Wahl
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

MOTHER
15. MAIDEN NAME: Mary Jane Lucas
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

17. INFORMANT (ADDRESS): T. E. Wade, Odessa, Mo.

18. BURIAL, ~~CREMATION, OR REMOVAL~~ PLACE: Mt. Tabor Cem. Odessa Mo. DATE: 11/18, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): L. J. Husman, Odessa, Mo.

20. FILED: Nov. 8, 1939 Mrs E. M. Goodwin, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Nov. 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from 11-4-, 1939, to Nov. 7, 1939

I last saw her alive on Nov. 7, 1939. Death is said to have occurred on the date stated above, at 6:00 p.m.

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

Pneumonia Labar (Rt. Lung).

Date of onset

92 ic

Other contributory causes of importance:
Influenza
Endocarditis Ch.
Myocarditis Ch.
Senility

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) [signature], M. D.

(Address) Odessa, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1/16/39

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 Irving L. Hausman

Licensed Embalmer No. 2541

P. O. Address Odessa Mo

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.