DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14150

Registration District No. 11 Primary Registration District No. 5014 Registrar's No. 32

1. PLACE OF DEATH:

(a) County Andrew

(b) ~~City or town~~ Rural Clay Township (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 88 yrs, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew

(c) City or town Rural Clay Township (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Melvira Wade 3

3. (b) If veteran, name war ------ 3. (c) Social Security No. ------

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Alfred Wade 6. (c) Age of husband or wife if alive years

7. Birth date of deceased 9 (Month) 3 (Day) 1851 (Year)

8. AGE: Years 88 Months 7 Days 24 If less than one day hr. min.

9. Birthplace Fillmore (City, town, or county) Mo. C (State or foreign country)

10. Usual occupation At home

11. Industry or business 1

FATHER
12. Name Edmond Wade
13. Birthplace Un known (City, town, or county) Ohio (State or foreign country) 1

MOTHER
14. Maiden name Elizabeth Rawling ~~Wade~~
15. Birthplace Un known (City, town, or county) Ohio (State or foreign country)

16. (a) Informant's own signature Mrs. Roy Chard

(b) Address Audubon Iowa

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 (Month) 29 (Day) 1940 (Year)

(c) Place: burial or cremation Gravell Wall

18. (a) Signature of funeral director E. C. Breit

(b) Address Savannah Mo.

19. (a) 4-27-1940 (Date received local registrar) (b) Mrs J. E. Barns by Mrs Jennie Rash (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 27 year 1940 hour 5 minute 45 p. M.

21. I hereby certify that I attended the deceased from Apr-28, 1940 to Apr-26, 1940 that I last saw h alive on Apr-26, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. Logan Wood (M. D. ~~or other~~)

Address Bolckow, Mo. Date signed 4/28-40

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 11
District File Number 540-640
Date Filed MAY 6 1940

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah Ga

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

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