

Registration District No. 283

Primary Registration District No. 4227

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Morehouse  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town Morehouse  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Nadine Marie Wader 360

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 10 10 24  
(Month) (Day) (Year)

8. AGE: Years 15 Months 7 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation D

11. Industry or business House work D

MOTHER FATHER { 12. Name William Wader  
13. Birthplace Desoto Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Bertha Coats  
15. Birthplace Clarkton Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant F.E. Taylor  
(b) Address Morehouse Mo.

17. (a) Burial (b) Date thereof 6/3/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bernie Mo.

18. (a) Signature of funeral director John Allett

(b) Address Sikeston Mo. 5 1316

19. (a) 9.3 1940 (b) Mo John Ferrish  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 2  
year 1940 hour 3; minute 10 a.m.

21. I hereby certify that I attended the deceased from 6-2-40 to 6-2-40  
that I last saw her alive on 6-2-40 and that death occurred on the date and hour stated above.

Immediate cause of death Concussion of Brain

Due to Blow to head while working at home fractured  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations no  
Of autopsy none

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence 6-2-40  
(c) Where did injury occur? Morehouse, New Madrid Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
On highway  
While at work? no (e) Means of injury Auto

23. Signature M. Henderson (M. D. or other) 1  
Address Sikeston, Mo. Date signed 6-3-40

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

21 PM  
9/8

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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed John A. [Signature]

Licensed Embalmer No. 2941

P. O. Address Liver to me

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **22356**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **603**

Primary Registration District No. **4387**

Registrar's No.

ROWENA MOORE

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**  
 (a) County New Madrid  
 (b) City or town Morehouse  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

**3. (a) PRINT FULL NAME** Madine Marie Wader

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced D  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one year
	<u>10</u>	<u>9</u>	<u>22</u>	hr. min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_  
 (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
 (Burial, cremation, or removal)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**19. MEDICAL CERTIFICATION**

20. DATE OF DEATH Month 6 day 2 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above.  
 Immediate cause of death Brain Concussion Duration? \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions fractured humerus  
 (Include pregnancy within 3 months of death)  
Rt femur fractured  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

**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) accident  
 (b) Date of occurrence 6-1-40  
 (c) Where did injury occur? On highway near Madine, Mo  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 On highway off highway  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury fallen into ditch

23. Signature M. G. Anderson M.D. or other \_\_\_\_\_  
 Address Director Mo Date signed 8-5-4

SUPPLEMENTARY

