

NOV 10 1940

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Fishing River  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Excelsior Springs Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 hrs.  
(Specify whether  
In this community 48 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay  
(c) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. 218 N. Kimbell Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? no. years.

8. (a) PRINT FULL NAME JOHN E. RYAN WADE

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

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

6. (b) Name of husband or wife Celia Wade 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased March 15 - 1892  
(Month) (Day) (Year)

8. AGE: Years 48 Months 6 Days 23 If less than one day hr. min.

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

10. Usual occupation grocery

11. Industry or business Meat Cutter

12. Name John Wade

13. Birthplace Ray Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Mattie Erwin

15. Birthplace Clay Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Celia Pauline Wade

(b) Address 218 N. Kimbell

17. (a) burial (b) Date thereof Oct. 10 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salmon

18. (a) Signature of funeral director Herbert Wade

(b) Address Excelsior Springs Mo.

19. (a) Oct 9 - 1940 (b) Mrs. Reb M. Cracken  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 8<sup>th</sup>  
year 1940 hour 2 minute 05 PM.

21. I hereby certify that I attended the deceased from 10-8-40  
1940, to 10-8, 1940

that I last saw him alive on 10-8, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococci Septicemia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

180  
While at work no (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Reginald H. Robinson (M. D. or other) \_\_\_\_\_

Address 116 South St. Date signed 10-9-40

Duration

2 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

4  
2  
1

26

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 11-13-40

**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 *W. Hocken Smith*  
Licensed Embalmer No. *3597*  
P. O. Address *Ev. & Union Springs, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **35287**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **198**

Primary Registration District No. **3011**

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

1. PLACE OF DEATH:

(a) County **Clay**  
(b) City or town **Flowler Springs Mo**  
(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)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

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.

3. (a) PRINT FULL NAME

**John Erwin Wade**

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

4. Sex **sm** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

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

8. AGE: Years **48** Months **6** Days **23** If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

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

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

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

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)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Oct** day **8** year **1946** 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 \_\_\_\_\_

**Streptococci Septicemia**  
Due to **Condition similar to Empyema involving pleura and lower abdominal area**

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (b) Means of injury \_\_\_\_\_

23. Signature **James B. [Signature]** (M. D. or other) \_\_\_\_\_  
Address **Flowler Springs Mo** Date signed **12/11/46**

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

SUPPLEMENTAL

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

