

FILED JUL 18 1943

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21468

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. 169

## 1. PLACE OF DEATH:

(a) County COLE  
 (b) City or town JEFFERSON CITY  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
ST. MARY'S HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 1/2 days  
 (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME LILY KATHERINE WADE

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased. MAY 22 41  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
0 0 12 hr. min.9. Birthplace GUTHRIE MO.  
(City, town, or county) (State or foreign country)10. Usual occupation Infant

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

12. Name WILLIS HERBERT WADE13. Birthplace GROVER COLORADO  
(City, town, or county) (State or foreign country)14. Maiden name DOROTHY SHADWICK15. Birthplace KANSAS CITY KANSAS  
(City, town, or county) (State or foreign country)16. (a) Informant WILLIS HERBERT WADE(b) Address GUTHRIE, MO.17. (a) Burial (b) Date thereof June 3, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mt. Carmel Cem. Callaway18. (a) Signature of funeral director Father Willis W. Wade(b) Address Guthrie, Mo.19. (a) 6/12/41 (b) W. B. Beaufort  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CALLAWAY  
 (c) City or town GUTHRIE  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. RURAL ROUTE # 1  
 (If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 2  
year 41 hour 12 minute 50 P.M.21. I hereby certify that I attended the deceased from MAY 31  
19 41, to JUNE 2 19 41that I last saw him alive on JUNE 2 19 41  
and that death occurred on the date and hour stated above.

Immediate cause of death

CARDIO-RESPIRATORY FAILUREDue to PREMATURITY, 7 mos. gestationDue to JAUNDICE HEMORRAGICA INTERNAL HEMORRHAGEOther conditions BLOOD DYSCRASIA?  
(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? \_\_\_\_\_

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

23. Signature W. B. Beaufort (M. D. or other) DAddress Jefferson City, Mo. Date signed 6/12/41

(Licensed Embalmer's Statement on Reverse Side)

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

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**