

No. 2
4-13-40
5-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23562

State File No. _____

FILLED AUG 28 1941

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 5904

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis

(c) Name of hospital or institution:
St. John's Hospital
(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 Albert Homer Wade

3. (b) If veteran, name war _____ 3. (c) Social Security No. 702-10-9912

4. Sex Male 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 _____

7. Birth date of deceased May 3-1868
(Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days 14 hr. _____ min. _____
If less than one day

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

10. Usual occupation pepper & fireman

11. Industry or business M. K. & G. R. R.

12. Name Christopher C. Wade

13. Birthplace Bedford Co Va
(City, town, or county) (State or foreign country)

14. Maiden name Mary T. Taylor

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

16. (a) Informant Bernard Wade

(b) Address Columbia, Mo.

17. (a) Removal (b) Date thereof 7/18/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Schell City, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) JUL 18 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Columbia
(If outside city or town limits, write "RURAL")

(d) Street No. 207 So. 5th. St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 1941 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 2, 1941, to July 19, 1941; that I last saw him alive on July 17, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Hypertrophic prostatic with distention
Myocardial degeneration, acute
Chronic Nephritis
Wascemia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Hypertrophic prostate with distention

Of operations _____

Of autopsy none

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 [Signature] (M. D. or other) _____

Address 958 Woodway Date signed 7/18/41

Duration _____

_____ years

_____ years

_____ days

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

Albert G. Koffer

Licensed Embalmer No.....

2971

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.