S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 11 1942

Registration District No. 178

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3011

State File No. 2042

Registrar's No. 2

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 12 days (Specify whether years, months or days)
In this community: unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 518 Main St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Herbert T. Wade

3. (b) If veteran, name war: World War

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife: none

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: June 27, 1895 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
46	6	10	hr. min.

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

10. Usual occupation: Bath House Helper-unemployed

11. Industry or business:

FATHER
12. Name: James Wade
13. Birthplace: Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Nellie Ervin
15. Birthplace: Missouri (City, town, or county) (State or foreign country)

16. (a) Informant: Hospital records, Veterans Administration, Excelsior Springs, Mo.
(b) Address:

17. (a) ~~Removal~~ Burial (Burial, cremation, or removal) (b) Date thereof: 1-8-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Salem Cemetery, Excelsior Springs, Mo.

18. (a) Signature of funeral director: Claude Prichard
CLAUDE PRICHARD
(b) Address: Excelsior Springs, Mo.

19. (a) 1-8-42 (Date received local registrar) (b) Mrs Rea McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 6th day: January year: 1942 hour: 9:45 minute: P. M.

21. I hereby certify that I attended the deceased from December 26, 1941 to January 6, 1942 that I last saw him alive on January 6, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis, pulmonary, active, far advanced

Due to:

Due to:

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

Major findings:
Of operations:

Of autopsy: as shown above

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: E.A. Welch
E.A. WELCH, M.D. (M. D. or other)
Address: Veterans Administration Date signed: 1-7-42
Excelsior Springs, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 2-10-45

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Spgs., 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, fact should be so stated above.