

FILED AUG 27 1943

State File No. _____
 Registrar's No. **3612**

Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Luke's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 Days
(Specify whether in this community _____ years, months or days) 50 years (Specify whether _____)

3. (a) PRINT NAME: MARGUERITE E WADE
FULL NAME: _____

3. (b) If veteran, name war: No **3. (c) Social Security No.:** None

4. Sex: Female **5. Color or race:** White
6. (a) Single, widowed, married, divorced, W. dow: 2 divorced, W. dow
6. (b) Name of husband or wife: George L Wade **6. (c) Age of husband or wife if alive _____ years**
7. Birth date of deceased: Aug 9 1889
(Month) (Day) (Year)

8. AGE: Years 54 Months 0 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace: St. Paul Minn
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: _____

MOTHER FATHER
12. Name: Smith
13. Birthplace: Ireland 4
(City, town, or county) (State or foreign country)
14. Maiden name: Mary
15. Birthplace: Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant: George J Wade
(b) Address: 5412 Brookside

17. (a) Burial **(b) Date thereof:** Aug 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Hill

18. (a) Signature of funeral director: Durb... & Cabin Co
(b) Address: 20 West Linwood

19. (a) 8-21-43 **(b) T. L. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson **48**
 (c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL") **8**
 (d) Street No. 5412 Brookside
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18th day August
 year 1943 hour 10:25 minute P M.

21. I hereby certify that I attended the deceased from: 12th August 1943
August 1943 to 18th August 1943
 that I last saw him/her alive on 18th August 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death: Sub-arachnoid Hemorrhage 6 days
 Duration _____

Due to: Encephalo-malaria

Due to: _____
 Other conditions (include pregnancy within 3 months of death):
43C

PHYSICIAN
Major findings: Sub-arachnoid Hemorrhage
Of autopsy: Encephalo-malaria
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? _____ **(e) Means of injury:** _____

23. Signature: Dr. Joseph Salsbery (M.D. or other) Dr. H.
 Address 1219 Bialto Blvd Date signed 8-20-43

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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..... *H. C. [Signature]*

Licensed Embalmer No. *2810*

P. O. Address. *H. C. [Signature]*

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.