

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 590

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Jefferson Barracks
(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 Adm. Mar. 2, 1944
(Specify whether years, months or days) unknown.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis Co.
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
(d) Street No. 24 West Wellington
(If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country -

3. (a) PRINT FULL NAME Fred B. WADE

3. (b) If veteran, name war World War #1
3. (c) Social Security No. 489-12-4438

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

6. (b) Name of husband or wife Mrs. Maggie Wade
6. (c) Age of husband or wife if alive unkn. years

7. Birth date of deceased February 11, 1893
(Month) (Day) (Year)

8. AGE: Years 51 Months 0 Days 24
If less than one day hr. min.

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

10. Usual occupation Hod Carrier

11. Industry or business -

MOTHER FATHER { 12. Name Daniel Wade
13. Birthplace Unknown Mississippi
(City, town, or county) (State or foreign country)
14. Maiden name Mary French
15. Birthplace Unknown Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant M. Schellig
(b) Address Clinical Clerk, VAF, Jeff. Bks., Mo.

17. (a) Burial (b) Date thereof 29 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director J. L. Lewis

(b) Address 2242 E. Webster Groves

19. (a) MAR 9 - 1944 (b) C. G. McSarran, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th,
year 1944 hour 12:30 minute P. M.

21. I hereby certify that I attended the deceased from March 2, 1944 to March 5, 1944
that I last saw him alive on March 5, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive and coronary arteriosclerotic heart disease with cardiac enlargement, myocardial damage and insufficiency.

Due to -

Other conditions Arteriosclerosis, general. Nephritis, chronic, arteriosclerotic.

Major findings: No operation.
Of operations -

Of autopsy No autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? no (Specify place of place)

Signature L. M. COCHRAN, M.D. (M. D. or other)

Address Chief Medical Officer Date signed 5/8/44.

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

96
0
0

96
1

Duration
About 2 years
Unknown
Unknown
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

J. C. Lewis

Licensed Embalmer No.

2027

P. O. Address

Wheeler Avenue

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.