

X32873

FILED APR 7 1944

Primary Registration District No. 6230

Registrar's No. _____

1. PLACE OF DEATH:

(a) County VERNON
(b) City or town METZ TWP. RURAL
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 70 YEARS years, months or days

3. (a) PRINT FULL NAME CLARA ADELA WADE.

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced D
6. (b) Name of husband or wife Divorced 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JUNE 18, 1862 (Month) (Day) (Year)

8. AGE: Years 81 Months 8 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) VIRGINIA (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name OSBORNE H. WADE
13. Birthplace VIRGINIA (City, town, or county) (State or foreign country)
14. Maiden name MARY COOK
15. Birthplace VIRGINIA (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. M.B. Wilkey
(b) Address 606 City, Okla.

17. (a) BUR. (Burial, cremation, or removal) (b) Date thereof 3-9-44 (Month) (Day) (Year)

(c) Place: burial or cremation RIDER CEMETERY

18. (a) Signature of funeral director R. H. No.

(b) Address _____

19. (a) 3-8-44 (Date received local registrar) (b) Charles (Registrar's signature) By ED

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County VERMONT
(c) City or town METZ (RURAL)
(d) Street No. 2 MULLEN BLVD (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7 year 1944 hour 8 minute 30 a. m.

21. I hereby certify that I attended the deceased from May 1, 1943 to March 7, 1944
that I last saw him alive on March 7, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
hypertension
Chronic Cor. Artery Disease

Other conditions (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 Charles (M. D. or other) _____
Address _____ Date signed 3/9/44

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

18000

RECEIVED

District Health Officer No. 7,

District File Number 3-44-311

Date Filed 4-5-44

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: John I Underwood

Licensed Embalmer No. 3585

P. O. Address Butler 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.