

S. No. 2
M-8-43
5-17-39
P1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37818

State File No. _____

FILED DEC 7 1944
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 931

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

1. PLACE OF DEATH

(a) County Greene Mo.
 (b) City or town Springfield Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 432 Ildereen Drive
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community about 7 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
 (c) City or town Springfield Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 132 Ildereen
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Thomas C. Wade
 3. (b) If veteran, name war UNK.
 3. (c) Social Security No. UNK.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife UNK.
 6. (c) Age of husband or wife if alive Dec. years
 7. Birth date of deceased Sept. 26, 1853
 (Month) (Day) (Year)

8. AGE: Years 91 Months 2 Days 0
 If less than one day _____ hr. _____ min.

9. Birthplace UNK. Kentucky
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____
 12. Name Joseph Wade
 13. Birthplace UNK. Kentucky
 (City, town, or county) (State or foreign country)
 14. Maiden name Nancy Starbuck
 15. Birthplace UNK. Alabama
 (City, town, or county) (State or foreign country)

16. (a) Informant Fred Wade
 (b) Address Osark Mo.
 17. (a) Burial (b) Date thereof Nov 28-44
 (Burial, cremation, or other) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Carmel

18. (a) Signature of funeral director T. B. Chaffin
 (b) Address Osark Mo.
 19. (a) 12-1-44 (b) S. W. Handley
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26
 year 1944 hour 10 minute 30 P. M.
 21. I hereby certify that I attended the deceased from Jan 1944 1944 to Nov. 26 1944
 that I last saw him alive on Nov. 26 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Heart trouble, valvular.
Prostate trouble
 Duration some years

Due to _____
 Due to _____
 Other conditions Senility 92d
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (c) 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? _____

18. (a) Signature of funeral director _____ (Specify type of place) _____
 While at work? _____ (c) Means of injury _____
 23. Signature J. W. Wade (M. D. certifier) _____
 Address Osark Mo. Date signed Nov 28-44

984

(Licensed Embalmer's Statement on Reverse Side)

44

100-111

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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, 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.