S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16842

Registration District No. [illegible] Primary Registration District No. 5481 Registrar's No.

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Robertsville Prairie Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 60 yrs

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

3. (a) PRINT FULL NAME Daisy Wade
3. (b) If veteran, name war
3. (c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Walter Wade
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased 10 (Month) 3 (Day) 1875 (Year)

8. AGE: Years 69 Months 7 Days 26 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) ? (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name Unknown
13. Birthplace " " (City, town, or county) ? (State or foreign country)
14. Maiden name Unknown
15. Birthplace " " (City, town, or county) ? (State or foreign country)

16. (a) Informant Walter Wade
(b) Address Robertsville MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove
18. (a) Signature of funeral director Casey & Lenox
(b) Address St Clair MO
19. (a) 5/31/1945 (Date received local registrar) P. J. Kinsella (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29 year 1945 hour 910 minute P. M.
21. I hereby certify that I attended the deceased from 2-25, 1945, to 5-29, 1945 that I last saw h.e.r alive on 5-29, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Ascites	3 Mo
Due to: Tuberculous Peritonitis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 13	
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:
(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 H. M. Denny (M. D. or other)
Address Union Mo Date signed 5-30-45

1120

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 6-12-45

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 Jno L Hughes

Licensed Embalmer No. 3008

P. O. Address Pacific 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.