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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 28 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22701

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6212

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital
Max c. Starkloff Memorial 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 615 Walnut Street 9 25
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MATTHEW WADE

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Apr (Month) 18 (Day) 1885 (Year)

8. AGE: Years 60 Months 2 Days 26 If less than one day hr. min.

9. Birthplace McLean (City, town, or county) Illinois 1 (State or foreign country)

10. Usual occupation Time Keeper

11. Industry or business Railroad

FATHER
12. Name John Wade
13. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name Mary Hickey
15. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant Margret Carlin
(b) Address 1107 Market Madison, Ills.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-17-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem Edwardsville Ill

18. (a) Signature of funeral director Proper Funeral Home
(b) Address Granite City Illinois

19. (a) JUL 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1945 hour 1:40 minute P M.

21. I hereby certify that I attended the deceased from July 2, 1945 to July 14, 1945
that I last saw him alive on July 14, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis far advanced

Due to

Due to

Other conditions mild cardiac decompensation
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy none permitted

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 1515 Lafayette Avenue Date signed 7/16/45

(Licensed Embalmer's Statement on Reverse Side)

6515

6515

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 Ketter

Licensed Embalmer No. 3880

P. O. Address St Louis 8, 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.