

FILED MAR 27 1946 **STANDARD CERTIFICATE OF DEATH**

Registration District No. 347 Primary Registration District No. 4177 Registrar's No. 1

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

1. PLACE OF DEATH:
 (a) County Sullivan
 (b) City or town Ferrville Buchanan
(If outside city or town limits, write "RURAL" and name of township)
 (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 5
(Specify whether)
 In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Sullivan
 (c) City or town Ferrville Buchanan
(If outside city or town limits, write "RURAL")
 (d) Street No. 105
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country —

3. (a) PRINT FULL NAME AXIE JANE 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 Single

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

7. Birth date of deceased Aug. (Month) 16 (Day) 1887 (Year)

8. AGE: Years 58 Months 6 Days 4 If less than one day hr. min.

9. Birthplace Sullivan Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business —

MOTHER FATHER { 12. Name George Wade

13. Birthplace Mo. (City, town, or county) (State or foreign country)

14. Maiden name Louisa Dixon

15. Birthplace Cutman Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Boy Wade

(b) Address Green City Mo

17. (a) Burial (b) Date thereof 9-22-46 (Month) (Day) (Year)
 (c) Place: burial or cremation Green City Bur.

18. (a) Signature of funeral director Frank H. Hunt, Sr.
 (b) Address Green City Mo
 19. (a) 4-28-1946 (Date received local registrar) (b) Kaura M. Shaw (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20 year 1946 hour 5 minute 30 a.m.

21. I hereby certify that I attended the deceased from Feb 20, 1946, to Feb 20, 1946, that I last saw h. — alive on —, 19—; and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy due to valvular disease of the heart Duration —

Due to —
 Due to —

Other conditions —
(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? —

While at work? — (Specify type of place) (e) Means of injury —

23. Signature W. Huntington MD (M. D. or other)
 Address Green City Mo Date signed 2-20-46

MAR 29 1946

RECEIVED

District Health Officer No. 10

District File No. 2-46-551

Date Filed MAR 19 1946

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 Archie W Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.