

No. 2  
8-43  
5-17-39  
X37923

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25997**  
Registrar's No. **4**

FILED AUG 12 1946

Registration District No. **347**

Primary Registration District No. **6177**

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

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Buchanan  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sullivan **105**

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Buchanan Twp.  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CORNELLES VIRGIL WADE

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15  
year \_\_\_\_\_ hour 8 minute 15 P.M.

4. Sex Male 5. Color or race white

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 Jan 4 1885  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 14 1946 to July 15 1946  
that I last saw him alive on July 15 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years 61 Months 6 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Sullivan Mo. 1  
(City, town, or county) (State or foreign country)

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name George Wade

13. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Louisa Dixon

15. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)

Major findings: Of operations 830

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Anna Guffey

(b) Address Green City Mo.

17. (a) Funeral (b) Date thereof 7-16-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green City Mo.

18. (a) Signature of funeral director John E. Hunt Sr.

(b) Address Green City Mo.

19. (a) July 25 1946 (b) Paula Shaw  
(Date received local registrar) (Registrar's signature)

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 M. Herington M.D. (M. D. or other)

Address Green City Mo. Date signed 7-16-46

RECEIVED  
District Health Officer No. 10  
District File Number 8-46-1463  
Date Filed AUG 10 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 Archibald 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.**