V. S. No. 2
00M—2-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 17 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34494

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 207

1. PLACE OF DEATH:

(a) County RANDOLPH
(b) City or town MOBERLY.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution McCormick Hosp. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 1 day
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BOONE 10
(c) City or town STURGEON 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME George Wilson Wade
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept. (Month) 30 (Day) - 1890 (Year)

8. AGE: Years 56 Months 0 Days 4 If less than one day hr. min.

9. Birthplace [redacted] BOONE Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Trucker
11. Industry or business
FATHER
12. Name Frank Wade O
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Ann Neal O
15. Birthplace Unknown
(City, town, or county) (State or foreign country)
16. (a) Informant Floyd Wade
(b) Address Sturgeon, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6-1946 (Month) (Day) (Year)
(c) Place: burial or cremation Locust Grove
18. (a) Signature of funeral director Barnes & Booth
(b) Address Sturgeon Mo.
19. (a) Oct 6-46 (Date received local registrar) (b) Lear William Lowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4
year 1946 hour 12 minute 20 p M.
21. I hereby certify that I attended the deceased from Oct 3, 1946, to Oct 4, 1946
that I last saw him alive on Oct 4, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Injuries
mashing entire body

Due to House falling on
patient

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

186 B
19

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident 4
(b) Date of occurrence 10-3-46
(c) Where did injury occur? au grain (City or town) Co. (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on farm
(Specify type of place)
While at work? yes (e) Means of injury Mashing O
23. Signature F. L. McCormick (M. D. or other) MD
Address Moberly Mo. Date signed 10-3-46

264

(Licensed Embalmer's Statement on Reverse Side)

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

33318

RECEIVED
District Health Officer No. 10
District File Number 10-46-1909
Filed OCT 14 1948
Date

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 A E Boothe

Licensed Embalmer No. 4087

P. O. Address Sturgeon, 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.