

FILED APR 14 1947

Registration District No. ....

Primary Registration District No. 1002

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1313 Euclid 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Thos W Wade

3. (b) If veteran, name war no 3. (c) Social Security No. unknown

4. Sex Male 5. Color or race Col  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Elizabeth Wade 6. (c) Age of husband or wife if alive 48 years  
7. Birth date of deceased March 19 1898  
(Month) (Day) (Year)

8. AGE: Years 54 Months 0 Days 19 If less than one day hr. min.

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

10. Usual occupation Leborer

11. Industry or business Leborer

12. Name Thos Wade

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

14. Maiden name unknown

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

16. (a) Informant Elizabeth Wade

(b) Address 1313 Euclid Ave

17. (a) Burial (b) Date thereof 4-5-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln

18. (a) Signature of funeral director Graham Burr

(b) Address 2304 Vine St

19. (a) 4-4-47 (b) Geraldine Holme  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1313 Euclid Ave  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 29 Year 1947  
hour 7:30 pm minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Mar 27 1947 to Mar 29 1947  
that I last saw him alive on Mar 27 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to Aneurysm Type Thromb 6 mo

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

Other conditions (Include pregnancy within 3 months of death) 95 lb

Major findings: Of operations \_\_\_\_\_

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

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 0

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

Address [Address] Date signed 4/2/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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

*Lawrence A. Jones*

Licensed Embalmer No. *4429*

P. O. Address *2500 Park K.C. 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.**