

FILED MAR 21 1947

Registration District No. 175

Primary Registration District No. 3036

Registrar's No. 22

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

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Aurora Mo.
(c) Name of hospital or institution: Aurora Hospital
(If not in hospital or institution, give street number or location)
(d) Length of stay: In hospital or institution about 2 hrs
In this community about 2 hrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Ila 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 married

6. (b) Name of husband or wife W. M. Wade

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased May 19 1890
(Month) (Day) (Year)

8. AGE: Years 56 Months 9 Days 7
If less than one day hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

12. Name Wm Baugh

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

14. Maiden name Susan
(City, town, or county) (State or foreign country)

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

16. (a) Informant Wm M. Wade

(b) Address Ponce De Leon

17. (a) Burial (b) Date thereof March 24
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ponce De Leon

18. (a) Signature of funeral director T. B. Chaffin

(b) Address Osark Mo.

19. (a) March 24 (b) Oral Mc Natt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stone 104
(c) City or town Ponce De Leon
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 26
year 1947 hour 11 minute 10 A.M.

21. I hereby certify that I attended the deceased from Jan 1, 1947, to Feb 26, 1947
that I last saw her alive on Feb 26, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Leukemia
Duration 1 year

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 94A

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:

(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) (c) Means of injury

23. Signature J. T. Wade (M. D. or other)
Address Osark Mo. Date signed 2-28-47

RECEIVED
District Health Officer No. 6,
District File Number 347-322
Date Filed MAR 13 1947

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 T. B. Cheffert

Licensed Embalmer No. 2192

P. O. Address Ozark 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.