

FILED AUG 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26744

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 3023 Registrar's No. 192

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HENRY</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Clinton</u>   |                               | c. CITY (If outside corporate limits, write RURAL and give township) <u>Shawnee Mound</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Clinton General Hospital</u>   |                               | d. STREET ADDRESS (If rural, give location) <u>none</u>   |  |
| 3. NAME OF DECEASED<br>a. (First) <u>MEREDITH</u> b. (Middle) _____ c. (Last) <u>WADE</u>   |                               |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>August 22-49</u>              |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>   | 8. DATE OF BIRTH <u>October 1-1893</u>                                 |
| 9. AGE (In years last birthday) <u>75</u>   |                               | 10. MONTHS <u>10</u>  | 11. DAYS <u>21</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>   | 11. BIRTHPLACE (State or foreign country) <u>Henry County Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                               | 13a. FATHER'S NAME <u>Peter Wade</u>  |  |
| 13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Johnson</u>   |                               | 14. NAME OF HUSBAND OR WIFE <u>Jessie</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                               | 16. SOCIAL SECURITY NO. <u>none</u>   |  |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Owens Wade</u>   |                               | ADDRESS <u>Clinton Mo</u>   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                                   |                               |   |  |
| MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>apoplexy</u>   |                               |   | INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u>                           |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertensive heart disease</u>   |                               |   | <u>3 yr</u>  |
| DUE TO (c) _____  |                               |   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |                               |   | <u>44-21</u>   |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 19c. DATE SIGNED  |                               | 19d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT SUICIDE HOMICIDE (Specify)  |                               | 20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 20c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |                               | 20d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)  |  |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                               | 20f. HOW DID INJURY OCCUR?  |  |
| 21. I hereby certify that I attended the deceased from <u>1946</u> , to <u>8-22</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8-21</u> , 19 <u>49</u> , and that death occurred at <u>1 A</u> m., from the causes and on the date stated above. |                               |   |  |
| 22a. SIGNATURE (Degree or title) <u>H. A. Walker M.D.</u>   |                               | 22b. ADDRESS <u>Clinton Mo.</u>   |  |
| 22c. DATE SIGNED <u>8-22-49</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>Clinton Mo.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE <u>August 24-49</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Englewood cemetery</u>  |                               | 23d. LOCATION (City, town, or county) (State) <u>Clinton Mo.</u>  |  |
| DATE REC'D BY LOCAL REG. <u>Aug. 24-49</u>  |                               | REGISTRAR'S SIGNATURE <u>Florence Adair</u> <u>422</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Fred H. Walker</u>  |                               | ADDRESS <u>Clinton Mo.</u>  |  |

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

RECEIVED  
District Health Officer No. 7,  
District File Number 7-49-102  
Date Filed 8-29-49

SEP 2 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Frederick C. Wilkerson Jr.

Licensed Embalmer No. 4510

P. O. Address Chattanooga, Tenn.

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.