

FILED AUG 15 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22759

BIRTH NO. 46729300 REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 217

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 716 Allton Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Boone County Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) KAREN	b. (Middle) DEE	c. (Last) WADE	4. DATE OF DEATH (Month) (Day) (Year) Aug. 9, 1950
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5. SEX Female /	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) /	8. DATE OF BIRTH July 25, 1950	9. AGE (In years last birthday) 14	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Columbia, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME William Wade	13b. MOTHER'S MAIDEN NAME Margaret Hunt	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Wade, 716 Allton Ave., Columbia, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 14 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7/25

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from July 25, 1950, to Aug 9, 1950, that I last saw the deceased alive on Aug 9, 1950, and that death occurred at 4 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Helen E. Yeager, M.D.	23b. ADDRESS 907 University Columbia	23c. DATE SIGNED Aug 10, 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 10, 1950	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) Columbia, Mo.
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DATE REC'D BY LOCAL REG. Aug 10 1950	REGISTRAR'S SIGNATURE Mrs R E Palmer	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Parson Funeral Service Columbia Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

104

RECEIVED 8  
DISTRICT HEALTH OFFICE No. 3  
District File Number \_\_\_\_\_  
Date Filed : 8-14-57

- 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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*Tom McHarg*

Signed .....  
Student Embalmer

Licensed Embalmer No. *3067*

P. O. Address *Columbia 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.