

FILED NOV 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39138

State File No. ....

REG. DIST. NO. 318

1003

Registrar's No. 9566

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary		e. STREET ADDRESS (If rural, give location) 1928 O'Fallon St.	
3. NAME OF DECEASED (Type or Print) a. (First) Wilder b. (Middle) Green c. (Last) Wade		4. DATE OF DEATH (Month) (Day) (Year) Nov. 7, 1950	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 3, 1915
9. AGE (In years last birthday) 35		IF UNDER 1 YEAR 8 Months	IF UNDER 24 HRS. 4 Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Flower Shop	11. BIRTHPLACE (State or foreign country) Aberdeen, Mississippi
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Green Vernon	
13b. MOTHER'S MAIDEN NAME Ida Beets		14. NAME OF HUSBAND OR WIFE Ivory Wade	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 499-05-6762	
17. INFORMANT'S SIGNATURE OR NAME Ivory Wade		ADDRESS 1928 O'Fallon St.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Les of Cervix Metastases</i> (b) <i>Les of Cervix</i> (c) _____ DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Secondary Anemia Shock</i>	
INTERVAL BETWEEN ONSET AND DEATH 3 mos 4 yrs. 1 day		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 171X	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:50 A. M., from the causes and on the date stated above.			
23a. SIGNATURE <i>Leona B. Smart</i>		23b. ADDRESS 4069 Easton Ave	
23c. DATE SIGNED 11/10/50		24a. BIRTHAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Nov. 13, 1950		24c. NAME OF CEMETERY OR REPOSITORY Washington Park	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE <i>O. J. Nash</i>	
DATE REC'D BY LOCAL REG. NOV 10 1950		REGISTRAR'S SIGNATURE <i>J. B. Sasater</i>	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*C. J. Nash*

Licensed Embalmer No. *2432*

P. O. Address *3847 Page*

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.