

FILED JAN 3 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39814

BIRTH NO. _____		REG. DIST. NO. <u>39</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>336</u>	
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		c. LENGTH OF STAY (In this place) <u>60 Years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		d. STREET ADDRESS (If rural, give location) <u>602 Wilkes Blvd.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Noyes Hospital</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 27, 1950</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>		b. (Middle) <u>OLIVE</u>		c. (Last) <u>WADE</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>May 19, 1870</u>	
9. AGE (In years last birthday) <u>80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Unknown Carter</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Jeff Davis Wade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Roy Wade, 602 Wilkes Blvd. Columbia, Mo.</u>			
19. 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, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fract. hips, bilateral.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension + anemia.</u> DUE TO (c) <u>Hypostatic broncho pneumonia.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>18 days</u> <u>19 days</u>	
19a. DATE OF OPERATION <u>12/13/50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fract. hips -</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Boone Co. Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) <u>? ? ? ?</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>?</u>			
22. I hereby certify that I attended the deceased from <u>Dec. 12, 1950</u> , to <u>Dec. 27, 1950</u> that I last saw the deceased alive on <u>Dec. 27, 1950</u> , and that death occurred at <u>11:44 a.m.</u> , from the causes and on the date stated above.							
23. SIGNATURE (Degree or title) <u>W. F. Stewart, M.D.</u>				23b. ADDRESS <u>Columbia, Mo.</u>		23c. DATE SIGNED <u>12/28/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 29, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Providence Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Boone County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Dec 28 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>31 Parker Funeral Service, Columbia, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

300  
484  
0

RECEIVED / -25/

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed 1-2-51

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 \_\_\_\_\_

*Chas L. Turing*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 4132

P. O. Address Columbus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.