

FILED JAN 3 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41396

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 5515 Registrar's No. 585

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived... If institution, residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Rural Shawnee Mound, Mo.</u> c. LENGTH OF STAY (in this place) <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>0420 Rural Shawnee Mound, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 mi West Shawnee Mound</u>		d. STREET ADDRESS (If rural, give location) <u>4 mi West Shawnee Mound</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Tessie</u> b. (Middle) <u>Sedgewick</u> c. (Last) <u>WADE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 25 1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED 2</u>	8. DATE OF BIRTH <u>Aug. 3 1879</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEKEEPER</u>	9. AGE (In years last birthday) <u>72</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEKEEPER</u>	11. BIRTHPLACE (State or foreign country) <u>Linn Co. Kansas</u>
13a. FATHER'S NAME <u>ANDERSON TILLMAN</u>		13b. MOTHER'S MAIDEN NAME <u>SARA LINDSEY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
14. NAME OF HUSBAND OR WIFE <u>MERIDITH 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 <u>Owen Wade</u> ADDRESS <u>Clinton Mo</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>cerebral hemorrhage</u> <u>3 wks.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		<u>331X</u>	
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? _____	
22. I hereby certify that I attended the deceased from <u>Oct 17 1951</u> , to _____, 19____, that I last saw the deceased alive on <u>Dec-25, 1951</u> , and that death occurred at <u>4 A. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>R. G. Powell M.D.</u> (Degree or title)		23b. ADDRESS <u>Clinton Mo.</u>	23c. DATE SIGNED <u>12-27-51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12/27/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>ENGLEWOOD CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>CLINTON Mo</u>
DATE REC'D BY LOCAL REG. <u>Dec-27-51</u>	REGISTRAR'S SIGNATURE <u>Florence Adair</u> 422	25. FUNERAL DIRECTOR'S SIGNATURE <u>Sickman &amp; Dunning</u> ADDRESS <u>Clinton Mo</u>	

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

420

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**RECEIVED** 12-21-51  
DISTRICT HEALTH OFFICE No. 3  
District File Number .....  
Date Filed 1-2-52 .....

**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 Robert L. Dunning

Licensed Embalmer No. 4710

P. O. Address Clinton 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.