

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**28220**

State File No. \_\_\_\_\_

No. 300  
10-48

**FILED AUG 31 1953**

BIRTH NO. 50815 REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 118

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission.)	
a. COUNTY <u>Franklin</u>	b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington Mo</u>	c. LENGTH OF STAY (in this place) <u>12 hrs</u>	a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RR. Augusta Mo</u>	
		d. STREET ADDRESS (If rural give location) <u>0920</u>	

<b>3. NAME OF DECEASED</b> (Type or Print)	a. (First) <u>NANCY</u>	b. (Middle) <u>LOU. C.</u>	c. (Last) <u>BADE</u>	<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Aug. 24-1953</u>
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<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>—</u>	<b>8. DATE OF BIRTH</b> <u>Aug. 24-53</u>	<b>9. AGE</b> (In years) (Month) (Day) (Year) (House) (Mts.) <u>12 hrs</u>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>Washington Mo</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
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<b>13a. FATHER'S NAME</b> <u>Walter Bade</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Darleen Heman</u>	<b>14. NAME OF HUSBAND OR WIFE</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)	<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Walter Bade</u>	<b>ADDRESS</b> <u>Augusta Mo R.R.</u>
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<b>18. CAUSE OF DEATH</b> 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.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>8 hours</u>  <u>8 hours</u>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Diaphragmatic spasm</u>		
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <u>Calcium tetany</u>  DUE TO (c)		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from 24 Aug, 1953, to 24 Aug, 1953, that I last saw the deceased alive on 24 Aug, 1953, and that death occurred at 8 P. m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <u>Raymond (Bozo) M.D.</u>	(Degree or title)	<b>23b. ADDRESS</b> <u>Washington, Mo.</u>	<b>23c. DATE SIGNED</b> <u>20 Aug 53</u>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>24b. DATE</b> <u>Aug. 25-53</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Fernie Boage</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>R.R. Augusta Mo</u>
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<b>DATE REC'D BY LOCAL REG.</b> <u>8/25/53</u>	<b>REGISTRAR'S SIGNATURE</b> <u>J.P. Steinhilber</u>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Olie Thelking</u>	<b>ADDRESS</b> <u>Augusta Mo</u>
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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

*Olie Shilkey*

Licensed Embalmer No. *3759*

P. O. Address *Augusta 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.