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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

10753

FILED DEC 16 1954

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10753					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.				b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION 4003 Cote Brilliante				e. STREET ADDRESS (If rural, give location) 2119 4003 Cote Brilliante							
3. NAME OF DECEASED (Type or Print)			a. (First) James		b. (Middle) E.		c. (Last) Wade				
4. DATE OF DEATH		(Month) Nov.		(Day) 22		(Year) 1954					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 8-7-1881		9. AGE (In years last birthday) 73			
IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 24 HRS. Hours _____		IF UNDER 24 HRS. Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen'l. Contractor			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Jackson, Missouri			12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Burrell Wade			13b. MOTHER'S MAIDEN NAME Amelia Green			14. NAME OF HUSBAND OR WIFE Louise Wade					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Louise Wade				ADDRESS 4003 Cote Brilliant e		
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.		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Branchopneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Nephrosclerosis DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 wk 6 mos			
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"/>			
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? 446X							
22. I hereby certify that I attended the deceased from May 30, 1954 , to Nov 22, 1954 , that I last saw the deceased alive on 11-21, 1954 , and that death occurred at 10 a. m. , from the causes and on the date stated above.											
23a. SIGNATURE Lea B. Markand				(Degree or title) _____		23b. ADDRESS 4069 1/2 Easton Ave		23c. DATE SIGNED 11-24-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 11-27-54		24c. NAME OF CEMETERY OR CREMATORY Local		24d. LOCATION (City, town, or county) Jackson, Missouri		(State) _____			
DATE REC'D BY LOCAL REG. NOV 26 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD			25. FUNERAL DIRECTOR'S SIGNATURE Russell Und., Co.					ADDRESS 2732 Pine Bl.	

(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.....
Signature of Student Embalmer

Signed *James B. Carter*

Licensed Embalmer No. *4168*
P. O. Address *St. J. ...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.