

FILED JAN 24 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

758

BIRTH NO. ....		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3020</u>		Registrar's No. <u>31</u>	
1. PLACE OF DEATH a. COUNTY <b>Franklin</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Franklin</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Washington</b>		c. LENGTH OF STAY (in this place) <b>12 hrs</b>		c. CITY OR TOWN <b>Robertsville</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Francis Hospital</b>				STREET ADDRESS (If rural, give location) <b>Prairie Twp</b> <span style="float: right;">0360</span>			
3. NAME OF DECEASED (Type or Print) <b>Walter W</b>		a. (First) <b>Wade</b>		c. (Last) <b>Wade</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 14, 1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Jan. 7, 1878</b>		9. AGE (In years last birthday) <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Evan Wade</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Bell</b>		14. NAME OF HUSBAND OR WIFE <b>Daisy Wade</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. ....		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Clarence Wade St. Clair, Mo</b>			
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) <b>Chronic Myocarditis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. <b>Acute surgical abdomen</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>None</b>		20. AUTOPSY? <b>4222</b> YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		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>1/14, 1955</u> , to <u>1/14, 1955</u> , that I last saw the deceased alive on <u>1/14, 1955</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <b>W. D. Stumback M.D.</b> (Degree or title)				23b. ADDRESS <b>Union Mo</b>		23c. DATE SIGNED <b>1/15/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Jan. 17, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Lonedell, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>1/15/55</b>		REGISTRAR'S SIGNATURE <b>J. L. Heidman</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. J. Lend</b>		ADDRESS <b>St. Clair, Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

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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 *K. M. Leno*.....

Licensed Embalmer No. *3601*

P. O. Address *St. Louis,*

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.