

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

322238

STATE FILE NUMBER

FILED OCT 4 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4327

300 0
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u>			Length of stay in lb <u>35 mo.</u>		d. STREET ADDRESS (If outside, give location) <u>502 Wallace</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rolla Wade</u>				4. DATE OF DEATH Month Day Year <u>September 27, 1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-10-1906</u>		9. AGE (In years last birthday) <u>51</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Air Conditioning Inc.</u>		11. BIRTHPLACE (City and state or country) <u>Post Oak Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Thomas Arroy Wade</u>			13b. MOTHER'S MAIDEN NAME <u>NANNIE LOW WELSH</u>			14. NAME OF HUSBAND OR WIFE <u>JAUNITA BEARY</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>565-01-6500</u>		17. INFORMANT Address <u>ROLLA B. WADE JR. 502 WALLACE K.C. Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral contusions and lacerations</u>							INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>multiple skull fractures</u>							<u>8902⁶</u>		
DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>fractures of rt clavicle, scapula, and hand.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.) <u>Fell from scaffolding at Truman Corner's Shopping Center landing on back of head and rt. shoulder.</u>						
20c. TIME OF INJURY Hour Month, Day, Year <u>1:26 p.m. 9-16-57</u>									
20d. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Truman Corner's Shopping Center</u>			20f. CITY, TOWN, OR LOCATION <u>Manhiew</u>		COUNTY <u>Jackson</u> STATE <u>Mo</u>		
21. I attended the deceased from <u>1:30 p.m. 9-16-57</u> to <u>9-17-57</u> and last saw her/him alive on <u>9-16-57</u> Death occurred at <u>539 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Raymond J. Caffrey M.D.</u>				22b. ADDRESS <u>1120 130th Manhiew, Mo.</u>			22c. DATE SIGNED <u>9-17-57</u>		
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9-19-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. Washington</u>		23d. LOCATION (City, town, or county) (State) <u>K.C. Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Sheil FUNERAL Home K.C. Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-17-57</u>		26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>				

Raymond J. Caffrey, USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Occur, tubular, etc. must use only standard nomenclature in their report. No symptoms were reported. All diseases in Part I must be causally related.



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 *Harold D. Reich*

Licensed Embalmer No. *4998*
P. O. Address *Kansas City*

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.