

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035527

FILED VS OCT 30 1959 71

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3012 Registrar's No. 96

ENDED

1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Length of stay in 1b <u>Lifetime</u>		c. CITY OR TOWN <u>Excelsior Springs</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>336 E. Broadway</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>336 E. Broadway</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Frederick</u> Last <u>Wade</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>13</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-27-1914</u>	9. AGE (last birthday) <u>45</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Excelsior Springs, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>John E. Wade</u>			13b. MOTHER'S MAIDEN NAME <u>Clelia Miller</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWII</u>			16. SOCIAL SECURITY NO. <u>491-01-9545</u>		17. INFORMANT Address <u>Clelia Wade, 336 E. Broadway, Ex. Spr., 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>Coronary occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____									
20d. INJURY OCCURRED WHILE AT WORK <input 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>6-2-59</u> to <u>10-13-59</u> and last saw <sup>her</sup> him <u>alive</u> on <u>9-3-59</u> Death occurred at <u>8:00 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>George E. Sanders M.D.</u>				22b. ADDRESS <u>Excelsior Springs, Mo.</u>			22c. DATE SIGNED <u>10-15-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-15-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lawson</u>		23d. LOCATION (City, town, or county) <u>Lawson, Missouri</u>		23e. (State)		
24. FUNERAL DIRECTOR ADDRESS <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>10-22-59</u>		26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 30 1959 SA

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OCT 30 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Ralph Van Landingham

Licensed Embalmer No. 4009

P. O. Address Bellevue Springs, N.Y.

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.