

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 19 1960 149

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. _____

6257-59-046879

| | | | | | | | |
|--|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY | | Length of stay in 1b 20 yrs | | c. CITY OR TOWN KANSAS CITY | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION 4908 BROOKSIDE | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 4908 BROOKSIDE | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last LINDEN FOY WADE | | | | 4. DATE OF DEATH Month Day Year DEC 28, 1959 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 11 12 93 | 9. AGE (last birthday) 66 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BANKER AND CATTLE RAISER | | | 10b. KIND OF BUSINESS OR INDUSTRY LA MONTE MISSOURI | | 11. BIRTHPLACE (City and state or country) USA | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME WILBUR D. WADE | | | 13b. MOTHER'S MAIDEN NAME ANNA MARGARET SNODDY | | 14. NAME OF HUSBAND OR WIFE CHRISTINE R. WADE | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 489 22 5188 A | 17. INFORMANT MRS. HOWARD KENT 5127 SUNSET DR | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest by Thrombosis</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 wks. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <i>Cerebral Artery Atherosclerosis</i> | | | | | 3 years. |
| | | DUE TO (c) <i>Atherosclerosis - generalized</i> | | | | | 3 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Nephrotic megal.</i> | | | | | | 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 checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m. | 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 <i>October 1957</i> to <i>12-28-59</i> and last saw her/him alive on <i>October 1956</i> Death occurred at <i>1:10 P.</i> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Deputy or title) <i>R.R. Bous M.D.</i> | | | | 22b. ADDRESS <i>4635 Wyandotte, K.C. 12, Mo</i> | | | 22c. DATE SIGNED <i>12/29/59</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE DEC 30, 1959 | 23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEM | | 23d. LOCATION (City, town, or county) KANSAS CITY MO. | | (State) |
| 24. FUNERAL DIRECTOR D. W. NEWCOMER'S SON K.C. MO. | | | | 25. DATE RECD. BY LOCAL REG. <i>12-29-59</i> | 26. REGISTRAR'S SIGNATURE <i>Steve Marshall</i> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DEATH

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

Albert L. Savage

Licensed Embalmer No. 4872

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.