

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH - 76-1-003785

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1117 STATE FILE NUMBER

FILED VS FEB 9 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>years</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6042 Southwest</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6042 Southwest</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>L</u> Last <u>Wade</u>	4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>1961</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>9-26-1896</u>	9. AGE (last birthday) <u>64</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>Salesman (retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Winley Pharmaceutal Company</u>	11. BIRTHPLACE (City and state or country) <u>Fayetteville, N. Carolina</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	--	--

13a. FATHER'S NAME <u>Albert Wade</u>	13b. MOTHER'S MAIDEN NAME <u>Lucy Clark</u>	14. NAME OF HUSBAND OR WIFE <u>Esther Wade</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>	17. INFORMANT Address <u>Mrs. Esther Wade, 6042 Southwest Avenue</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>Cardiac Failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio Sclerosis Heart</u>	
	DUE TO (c) <u>420.0</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 Jan 6 to Feb 6 and last saw him alive on 31 Jan 61
Death occurred at 6:15 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>A. J. Catanzaro M.D.</u>	22b. ADDRESS <u>2705 Clifton Ave</u>	22c. DATE SIGNED <u>3 Feb 61</u>
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Feb 6 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Bethlehem Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
---	--------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <u>Math Hermann & Son, Inc. 2161 E. Fair Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 4 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith M.D.</u>
---	---	---

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Calvin M. Quay

Licensed Embalmer No. 3732

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.