

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Clay
Township.....
or
Village.....
or
City Liberty

Registration District No. 201 File No. 18565
Primary Registration District No. 5780 Registered No. 38
3017 (NO. Odd Fellows Home) St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Preston M. Wagner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Dec. 16 1860
(Month) (Day) (Year)

7 AGE 54 yrs. 7 mos. 7 ds. IF LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired shipping clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods House

9 BIRTHPLACE
(City or town, State or foreign country) Ohio

10 NAME OF FATHER Samuel Wagner

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country) Va.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER D D D
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Minnie Wagner

(Address) 3307 Flora Ave. Kas. City

15

Filed June 28 1915 W. H. Johnson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 22 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 1st 1915 to June 21 1915 that I last saw him alive on June 20 1915 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Locomotor Atrophy

(Duration) 10 yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Matthews M. D.

June 28 1915 (Address) Liberty Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence Kas. City Mo.

19 PLACE OF BURIAL OR REMOVAL

Kas. City Mo.

DATE OF BURIAL

June 26 1915

20 UNDERTAKER

Stine & McClure Co.

ADDRESS

Kas City

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 8 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first; the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc.; when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

1 PLACE OF DEATH

County Clay
 Township or Village or City Liberty

Registration District No. 201 File No.
 Primary Registration District No. 3012 Registered No. 38

2 FULL NAME

Preston M. Wagner

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH
 (Month) (Day) 191..... (Year)

7 AGE
 yrs..... mos.....
 If LESS than 1 day..... hrs. or..... min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9 BIRTHPLACE
 (City or town, State or foreign country).....

PARENTS
 10 NAME OF FATHER.....
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country).....
 12 MAIDEN NAME OF MOTHER.....
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country).....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant).....
 (Address).....

15 Filed 9/9/15 191.....
Joseph Gordon Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
June, 21 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191..... to 191.....
 that I last saw him..... alive..... 191.....
 and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:
 Satisfactory Information Supplied.

CONTRIBUTORY (Secondary).....
 (Duration)..... yrs..... mos..... ds.
 (Signed)..... M. D.
 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
 At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
 Where was disease contracted if not at place of death?.....
 Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Kansas City Mo. DATE OF BURIAL 6-26 191.....

20 UNDERTAKER Stuart McClure ADDRESS Kansas City Mo.

Original file, date JUN -- 1915, 19.....

All information called for must be written on this Supplementary Certificate.

N. B. - Every item of information must be carefully supplied. AGE, SEX, and CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS - should state exact statement of OCCUPATION is very important.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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