

OCT 29 1927

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

Do not use this space.

29361

1. PLACE OF DEATH

County Vernon
Township Henry
City Stotesbury (No.) St. Ward)

879 879
Registration District No. 876
Primary Registration District No. 6167

File No.
Registered No.

2. FULL NAME

Mrs. Angelina Wagner
(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

Wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

11

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

69

9

18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

Housewife 82
97

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Jacksonville
Ills.

10. NAME OF FATHER

J. M. Dumbor

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Ills.

12. MAIDEN NAME OF MOTHER

Folts

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Bethlehem
Pa.

14.

INFORMANT Miss Stella Wagner
(Address) Stotesbury, Mo.

15.

FILED 10-5-27 1927 Scott P. Child
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

9-29th 1927

17.

I HEREBY CERTIFY, That I attended deceased from Sept. 24th 1927, to Sept. 27th 1927 that I last saw h. alive on Sept. 27th 1927, and that death occurred, on the date stated above, at 7-9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage, right
hemiplegia.

(duration) yrs. mos. 6 da.
CONTRIBUTORY arteriosclerosis
(SECONDARY) (duration) 30y yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

17-11-27
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical signs

(Signed) Scott P. Child, M. D.

, 19 (Address) Richards, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

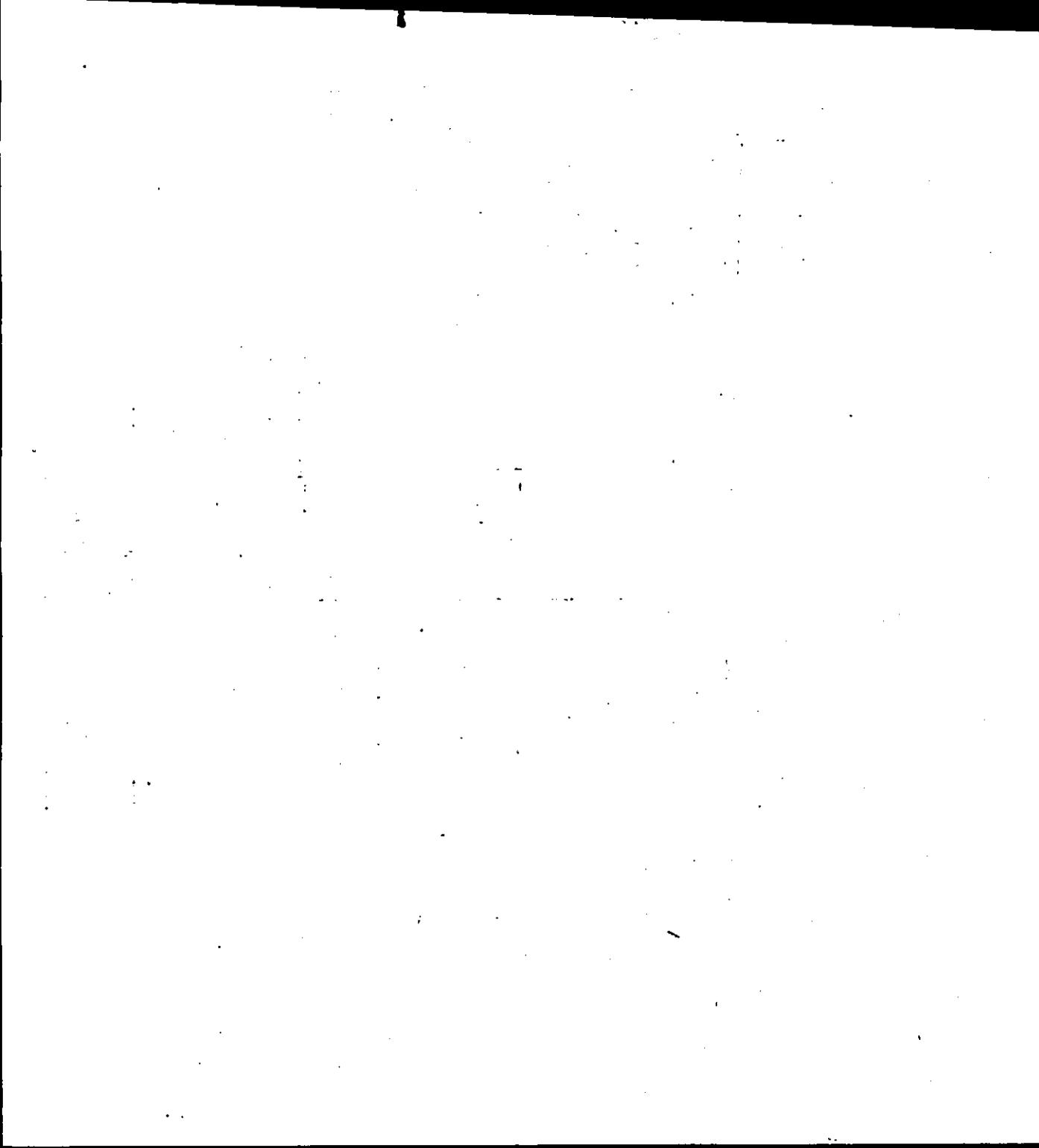
Hoover Church Cemetery 10-28 1927

20. UNDERTAKER

ADDRESS

Cherry St. Votts, Mo.

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



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Wenon Registration District No. 879 File No. 5
 Township Henry Primary Registration District No. 6167 Registered No.
 City (No.) St. Ward

2. FULL NAME Mrs. Angeline Wagner
 (a) Residence. No. St. Ward
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-11-1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 9 18

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

9. BIRTHPLACE (CITY OR TOWN) Jacksonville
 (STATE OR COUNTRY) Ills

10. NAME OF FATHER Wm DuBois

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ills
 (STATE OR COUNTRY) Ills

12. MAIDEN NAME OF MOTHER Foltz

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bethlehem Pa
 (STATE OR COUNTRY) Pa

14. INFORMANT Mrs. Della Wagner
 (Address) Statesbury Mo

15. FILED 11/10, 1917 W A Williams
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-29-27

17. I HEREBY CERTIFY That I attended deceased from Sept 27, 1927, to Sept 27th, 1927 that I last saw h. at Sept 27th, 1927, and that death occurred, on the date stated above, at 7-a-m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage, right hemiplegia
 (duration) 4 yrs. 6 mos. 4 da.

CONTRIBUTORY Arteriosclerosis
 (SECONDARY) (duration) 304 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical signs
 (Signed) Scott P. Child, M. D.
 , 19 (Address) Richards no

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hoover Church Cemetery DATE OF BURIAL 10-2nd 1927

20. UNDERTAKER Cherney ADDRESS St. Scott Van

N. B.—Every item of 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENT

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