

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

Do not use this space

30076

1. PLACE OF DEATH
County Greene Registration District No. 318
Township Springfield Primary Registration District No. 12001
City Springfield (No. 2308) N. Main St. _____ Ward _____
Registered No. 640

2. FULL NAME Rilda Wagner
(a) Residence. No. 2308 N. Main 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED, (write the word) married
6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 20 - 1856
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
71 5 0
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ind.
(STATE OR COUNTRY)
10. NAME OF FATHER Franklin Clemens
11. BIRTHPLACE OF FATHER (CITY OR TOWN) N. Y.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Margaret Atkins
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) N. Y.
(STATE OR COUNTRY)

14. INFORMANT E.H. Wagner
(Address) Springfield, Mo.
15. FILED 10/20, 1927 Oct 27 W.H.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-19 1927
17. I HEREBY CERTIFY, That I attended deceased from July 6, 1927, to Oct 19, 1927 that I last saw him alive on Oct 19, 1927, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senility, refer to page 114B
162
CONTRIBUTORY lung cancer
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.
(duration) _____ yrs. _____ mos. 21 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) M. J. Armstrong, M. D.
, 19 _____ (Address) Springfield, 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 Green Lawn cemetery DATE OF BURIAL Oct 20, 1927
20. UNDERTAKER W. Klingner & Co. ADDRESS 224 E. Conil
Springfield, Mo.

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.

It is stated EXACTLY. PHYSICIANS should state
in their OCCUPATION is very

100-100000

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Greene Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 2001 Registered No. 641
 City Springfield (No. _____) St. _____ Ward _____

2. FULL NAME

Rilda 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
 (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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14.

INFORMANT _____ (Address) _____

15.

FILED 10/20/27 O. H. H. H. H. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 19 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that

that I last saw h. _____ on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility infirmity of age
~~Not tubercular just brain water~~

CONTRIBUTORY Lung abscess due to infection (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

_____, 19____ (Address)

*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 _____

20. UNDERTAKER _____ ADDRESS _____

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SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated 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

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