

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

Do not use this space.

1. PLACE OF DEATH

County Franklin  
Township Central  
City (No. 1)

Registration District No. 244  
Primary Registration District No. V-409-B

File No. 26945  
Registered No. 16  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Ruth Ellen 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 18 1918

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
10 2 22 — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) St. Clair  
(STATE OR COUNTRY) MO.

10. NAME OF FATHER Wils F Wagner

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

12. MAIDEN NAME OF MOTHER Jessie E. Deaton

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

14. INFORMANT Wils F Wagner  
(Address) St. Clair, Mo.

15. FILED 8/9, 28 W. E. Kitchell  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9th 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug 9th 1928 to Aug 9th 1928  
that I last saw her alive on Aug 7th 1928, and that death occurred, on the date stated above, at 7:30 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

accidental Burn

CONTRIBUTORY (SECONDARY) acute Nephritis & uremia  
(duration) — yrs. — mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms  
(Signed) C. F. Briesleb, M. D.  
Aug 9, 1928 (Address) St. Clair, 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 Greenwood DATE OF BURIAL 8-10-1928

20. UNDERTAKER Cory & Co. ADDRESS St. Clair.



**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 Dickinson  
Township Central  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 294  
Primary Registration District No. 8-409-B

File No. \_\_\_\_\_  
Registered No. 16  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Ruth Ellen Wagner

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)  
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 <u>4</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9 1928

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that  
death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

accidental burn  
from stove & fire with coal  
if a can. can caught  
fire & he thrown it out  
acute nephritis & side

CONTRIBUTORY (SECONDARY)  
uremia (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 \_\_\_\_\_

*Did a house  
burn up  
in this case?  
No.*

14. INFORMANT \_\_\_\_\_  
(Address) \_\_\_\_\_  
15. FILED 10/12/28 W.E. Welch  
REGISTRAR

should be stated EXACTLY. PHYSICIANS should state  
ed. Exact statement of OCCUPATION is very important.  
UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

N. B.—Every  
CAUSE OF D.  
REGISTRAR

*did not come in the 2007*

5-26945