

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

Do not use this space.

25844

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City *St. Louis* (No. *City Hospital*)

File No.

Registered No. 7014

St. Ward)

2. FULL NAME

(a) Residence No. *125* *Capitol* St., *22* Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *3* 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) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mark W. 1850*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 20 1850*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 | *2* | *12*

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) *Keokuk Iowa*
(STATE OR COUNTRY)

10. NAME OF FATHER *John Wagon*

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

12. MAIDEN NAME OF MOTHER *Wagon*

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

14. INFORMANT (Address) *City Hospital*

15. FILED *1929* *Mar 21* REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 2 1929*

17. I HEREBY CERTIFY That I attended deceased from *June 20*, 19*29*, to *July 2*, 19*29*, that I last saw him alive on *July 2*, 19*29*, and that death occurred on the date stated above, at *6:15 a.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Cerebral Hemorrhage
intense
Senility*

CONTRIBUTORY (SECONDARY) *17401*

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) *John Wagon, M.D.*
72, 19*29* (Address) *City Hospital*

*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 *Calvary Cemetery* DATE OF BURIAL *7-3 1929*

20. UNDERTAKER *McLaughlin 1631 mo. ave* ADDRESS

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.

RECORD WITH OBTAINING INFORMATION—THIS IS A PERMANENT RECORD

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2
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Amigan