

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. Ms. Babst Sanitarium) St. _____ Ward _____

File No. 26284
 Registered No. 7498

2. FULL NAME

Charles John Wagner
 (a) Residence. No. 6600 Washington St., 12 Ward, St. Louis Co. Mo.
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Wagner
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 13, 1851
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
77 11 5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Salesman
 (b) General nature of industry, business, or establishment in which employed (or employer). Retired 5 years.
 (c) Name of employer Unknown

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

PARENTS
 10. NAME OF FATHER Unknown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Wm Wagner
 (Address) 2719 Woodson Rd.

15. FILED 19 Wm Wagner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-18-1929
 17. I HEREBY CERTIFY, That I attended deceased from 7-17, 1929, to 7-18, 1929, that I last saw him alive on 7-18, 1929, and that death occurred, on the date stated above, at 1:30 p m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
930 (duration) yrs. mos. ds.
107 ?

CONTRIBUTORY (SECONDARY) Arteriosclerosis
 (duration) yrs. mos. ds.

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 findings
 (Signed) James A. Forster M. D.
19 (Address) 3903 Olive

*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 St. Peters DATE OF BURIAL July 20 1929

20. UNDERTAKER Shepard Funeral Home ADDRESS 1167-69 Hamilton Ave.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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