

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

Do not use this space.

30286

1. PLACE OF DEATH

County Cassell Registration District No. 135
 Township Cassell Primary Registration District No. 3210
 City Cassell (No. _____) St. _____ Ward _____

2. FULL NAME

Charles D. Wageman
 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. ~~MARRIED~~ ~~WIDOWED~~ ~~OR~~ ~~DIVORCED~~
 HUSBAND OF Fannie May Wageman
 (or) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-11-1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 0 12

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

9. BIRTHPLACE (CITY OR TOWN) Nelson County
 (STATE OR COUNTRY) Kentucky

10. NAME OF FATHER John R. Wageman

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

12. MAIDEN NAME OF MOTHER Martha Dykes

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

14. INFORMANT Mrs. C. D. Wageman
 (Address) Cassell, Mo.

15. FILED 9/23 1929 Mrs. E. E. Fambler
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-23 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-1-27, 19____, to 9-23-29, 19____, that I last saw him alive on 9-23-29, 19____, and that death occurred, on the date stated above, at 1:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Interstitial Nephritis -
Acute Regurgitation
Fortifying Empyema

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

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) R. H. Brewer M. D.

928 1929 (Address) Cassell 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 Catholic Cem DATE OF BURIAL 9/25-1929

20. UNDERTAKER Willis Pro ADDRESS Cassell Mo

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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