

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

Do not use this space.

33211

1. PLACE OF DEATH  
 County Carroll Registration District No. 134  
 Township Ridge Primary Registration District No. 4075  
 City Bosworth (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Nelson Wagy  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 31, 1861

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>61</u>	<u>8</u>	<u>8</u>	<u>26</u>	

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 27th 1929

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1929, to Oct 27, 1929 that I last saw him alive on Oct 27, 1929, and that death occurred, on the date stated above, at 3:30 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Parenchymatous Nephritis  
134 P

9. BIRTHPLACE (CITY OR TOWN) Pike CO. (STATE OR COUNTRY) ILL.

10. NAME OF FATHER George Wagy

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio. (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Dina Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) ILL.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (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  
 (Signed) all Boss Brown, M. D.  
 \_\_\_\_\_, 19 \_\_\_\_\_ (Address)

14. INFORMANT Robert Wagy  
 (Address) Bosworth

\*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.

15. FILED Oct 29 Mrs Boss Brown REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Wharton Comatery</u>	DATE OF BURIAL <u>10/30 1929</u>
20. UNDERTAKER <u>Louise Leonard Bosworth</u>	ADDRESS <u>no</u>

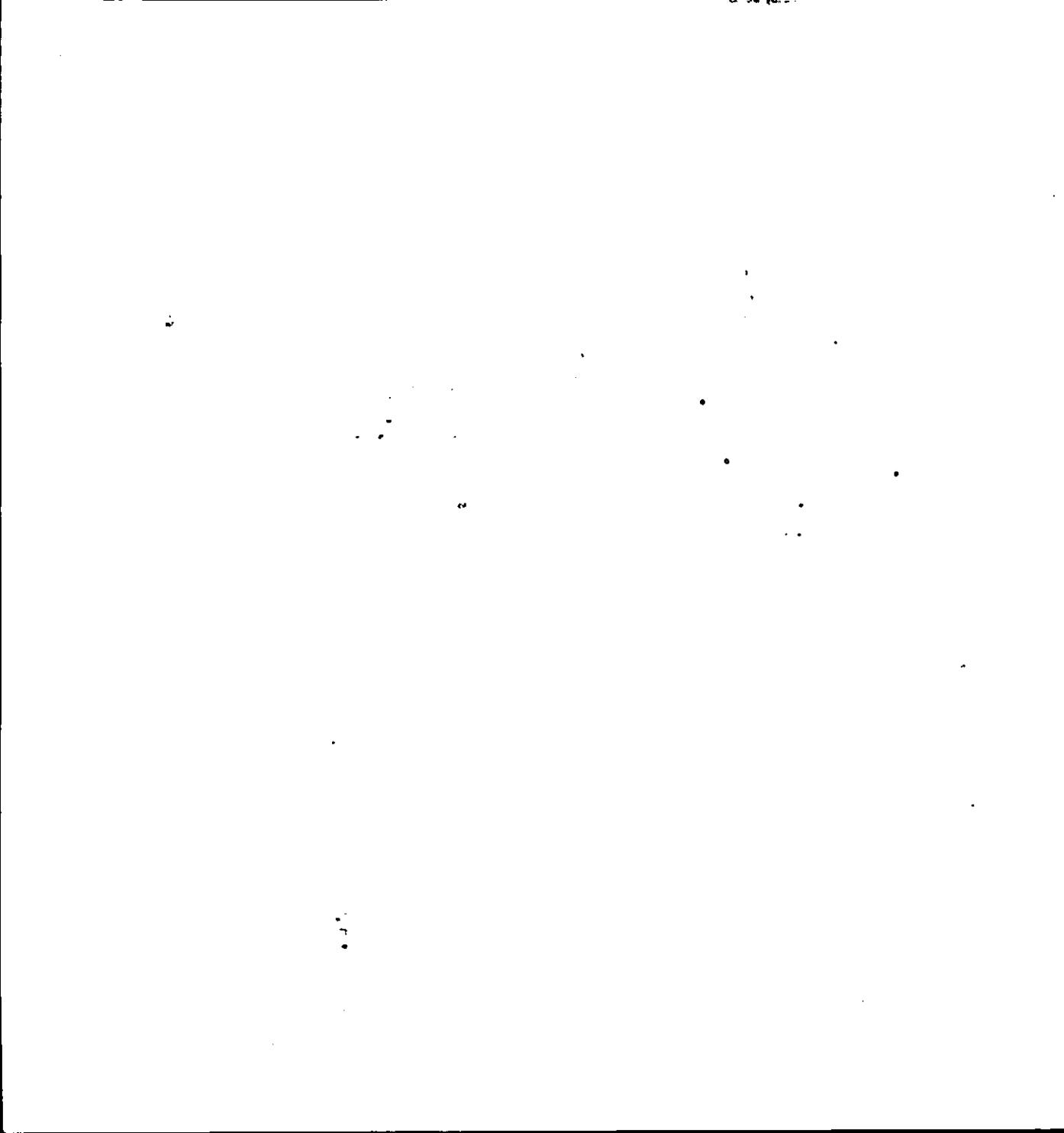
CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Carroll Registration District No. 134 File No. ....  
 Township Bosworth Primary Registration District No. 7075 Registered No. 16  
 City Bosworth (No. ....) St. .... Ward)

**2. FULL NAME**

(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 M 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) Jan 31 - 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ....hra. or ....min.  
61 8 26

**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).....  
 (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 19 Mrs. Boss Brown  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 27 - 1929

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:**

..... (duration) ..... yrs. .... mos. .... ds.  
 CONTRIBUTORY (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  
 19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-33221