

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

Do not use this space.

5222

**1. PLACE OF DEATH**

County Jackson Registration District No. 6990  
 Township Kaw Primary Registration District No. 107  
 City Kansas City, Mo. (No. Wesley Hosp)  
Wesley Street

File No. 5222  
 Registered No. 880  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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.

John Tom Wagner  
Odessa, Mo.  
 (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 25 1930  
 17. \_\_\_\_\_

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jennie Wagner

I HEREBY CERTIFY That I attended deceased from Feb. 15, 1930, to Feb. 24, 1930, that I last saw him alive on Feb. 25, 1930, and that death occurred, on the date stated above, at 12 noon.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 9, 1859  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
72 8 18

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Bulbous parulosis  
2 PM  
3 PM

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

CONTRIBUTORY (SECONDARY) Automobile Injury  
signature of spinous process about 1/2 inch  
atlas fact (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Odessa, Mo.  
 (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED Odessa, Mo.  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_

10. NAME OF FATHER John Wagner

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

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

WHAT TEST CONFIRMED DIAGNOSIS? X Ray  
 (Signed) J. F. Murchey M. D.

12. MAIDEN NAME OF MOTHER Mrs. Lawrence

2. 25, 1930 (address) Kansas City, Mo.

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

\*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.

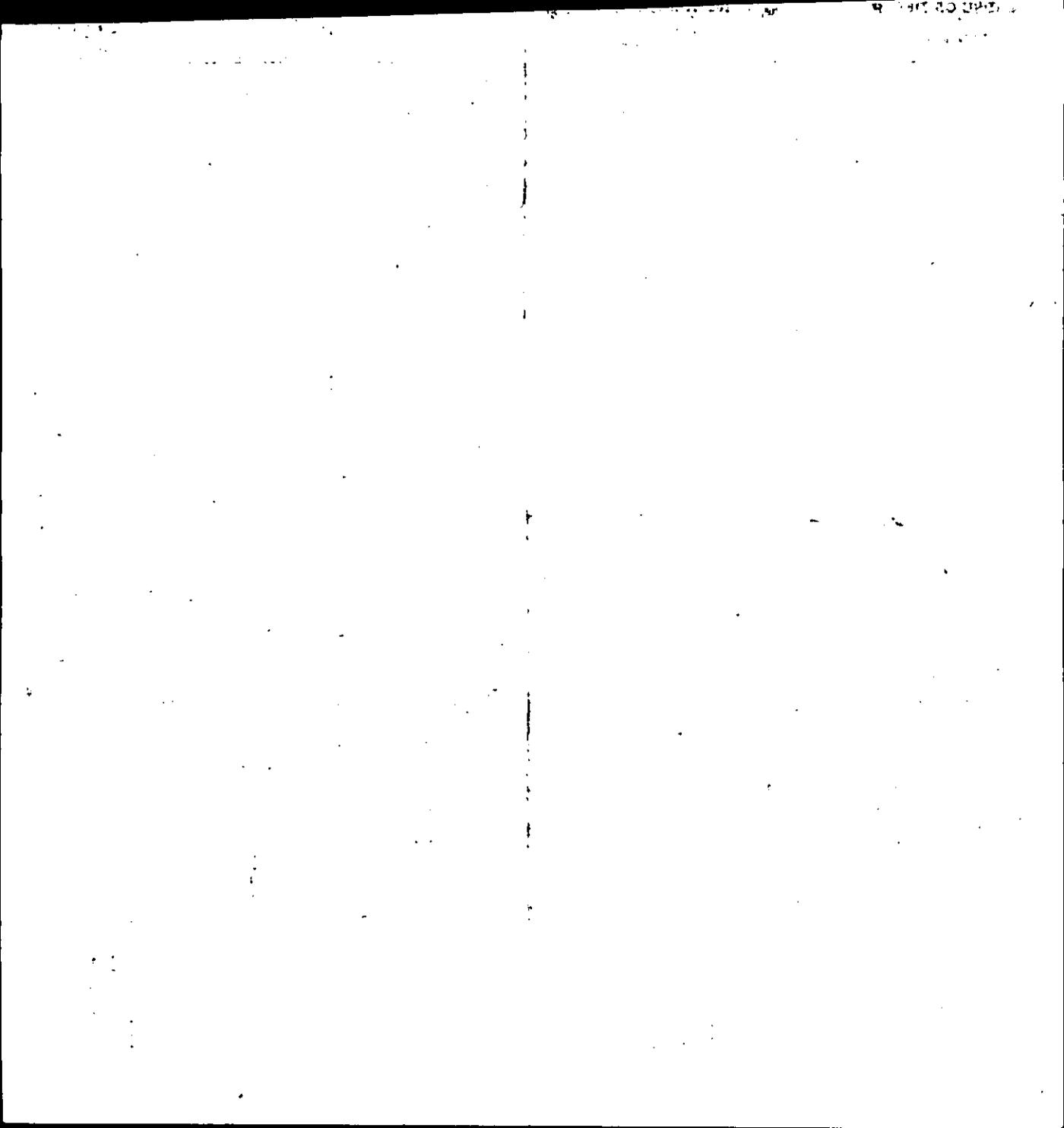
14. INFORMANT J. M. Reed  
 (Address) Odessa

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Odessa, Mo.  
 DATE OF BURIAL 2/28 1930

15. FILE NO. 25 30 M. M. Brown REGISTRAR  
act

20. UNDERTAKER R. C. Hummer  
 ADDRESS Odessa

CAUSE OF DEATH in plain terms, so that it may be understood by laymen.



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ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County..... Registration District No. 399 File No. 5322  
 Township..... Primary Registration District No. 1002 Registered No. 880-  
 City Kansas City (No. ....) St. .... Ward)

**2. FULL NAME**

John Tom Wagoner

(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 (write the word) m

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 than 1 day, hrs. or min.

**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 2/25 30 M. M. Carow REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 25 1930

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Bulbar Paralysis  
Automobile collision  
 (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) auto injury  
Automobile collision  
 (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. Odessa Mo

DID AN OPERATION PRECEDE DEATH? no DATE OF 10 201

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam

(Signed) J. F. Muehler M. D.

8-23 1930 (Address) 726 Lathrop Bldg

\*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

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.

5-5222