

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

Do not use this space.

216022737

1. PLACE OF DEATH

County Jackson
Township
City Kansas City (No. 1007 Summit 1002)

Registration District No. 399
Primary Registration District No.

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Ruth Anne Wagner
(a) Residence, No. 1007 Summit St., 1 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 15 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Infant</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>1-8-1930</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>1</u>	<u>5</u>	<u>15</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Harry Wagner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Linn Co.
(STATE OR COUNTRY) Kansas
12. MAIDEN NAME OF MOTHER Emma Miller
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) White Hall
(STATE OR COUNTRY) Montana

14. INFORMANT Harry Wagner
(Address) 1007 Summit

15. FILED 6/23/31 M.M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-23-1931
17. I HEREBY CERTIFY, That I attended deceased from 5-10, 1931, to 6-23, 1931, that I last saw her alive on 6-7, 1931, and that death occurred, on the date stated above, at 1:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
7 Pertussis (Whooping Cough)
1070A
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.
(1) measles = 14 days
(2) Broncho pneumonia 12 days
(3) acute otitis media 10 days

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? Physical Findings
(Signed) John H. Luke, M. D.
, 19 (Address) 320 Brotherhood Bldg. K.C. Kan

*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 W.H. Hope - K.C. Kansas DATE OF BURIAL 6-24-1931

20. UNDERTAKER R.D. Hultore ADDRESS K.C. Kansas

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.

