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

Do not use this space.
1934 - 1 - 8
1850 - 9 - 28
83 3 18

1. PLACE OF DEATH
County Crawford
Township ~~[illegible]~~
~~City~~ Meramac
Registration District No. 231
Primary Registration District No. 5314
File No.
Registered No.
(No. ..... St. ..... Ward)

2. FULL NAME Sietina Wagner
(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 F
4. COLOR OR RACE W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elmer Wagner
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 20-1850
7. AGE YEARS 83 MONTHS 3 DAYS 18 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) Henry County
(STATE OR COUNTRY) Iowa
PARENTS
10. NAME OF FATHER Thomas Adams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Sahra Farmer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ills.
(STATE OR COUNTRY)
14. INFORMANT Mrs Louis W. Kapelman
(Address) Bourbon Mo.
15. FILED 1-30, 1934 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/8 - 1934
17. I HEREBY CERTIFY, That I attended deceased from July, 1932, to Jan 8, 1934 that I last saw her alive on Dec 33, 19.., and that death occurred, on the date stated above, at 6 P. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
(duration) 12 yrs. 6 mos. ds.
CONTRIBUTORY (SECONDARY) [illegible]
(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) [signature], M. D.
, 19 (Address) Steeleville 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 Hensley Cemetery near Maysfield Mo
DATE OF BURIAL 1/10 1934
20. UNDERTAKER L J Jones Steeleville Mo
ADDRESS

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.