

REC'D APR 15 1938

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

Do not use this space.

3 1. PLACE OF DEATH
County Wichita Registration District No. 19
Township 1 Primary Registration District No. 401B
City Rock Port (No.) St. Ward (No.)

2. FULL NAME Gerald A. Wagner 256
(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.

File No. 9985
Registered No.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-2-1938

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
✓ ✓ 3

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. -

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ✓

10. Date deceased last worked at this occupation (month and year) ✓ 11. Total time (years) spent in this occupation ✓

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rock Port, Mo.

13. NAME Oswill Wagner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rock Port, Mo.

15. MAIDEN NAME Gladys Langfitt

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rock Port, Mo.

17. INFORMANT (ADDRESS) Oswill Wagner, Rock Port, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hunter DATE 4-5-38

19. UNDERTAKER (ADDRESS) Grat Barstolmer, Rock Port, Mo.

20. FILED 4-10 55 Mary J. Chamberlain Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-5 1938

22. I HEREBY CERTIFY, That I attended deceased from, 19, to, 19

I last saw him alive on April 4, 1938. Death is said to have occurred on the date stated above, at 12:30 a.m.

The principal cause of death and related causes of importance were as follows:
The baby was toxic, most probably as the result of the mother having during pregnancy severe hepatitis. Very weak at birth.

Other contributory causes of importance: and poorly developed

Name of operation 151 Date of

What test confirmed diagnosis?

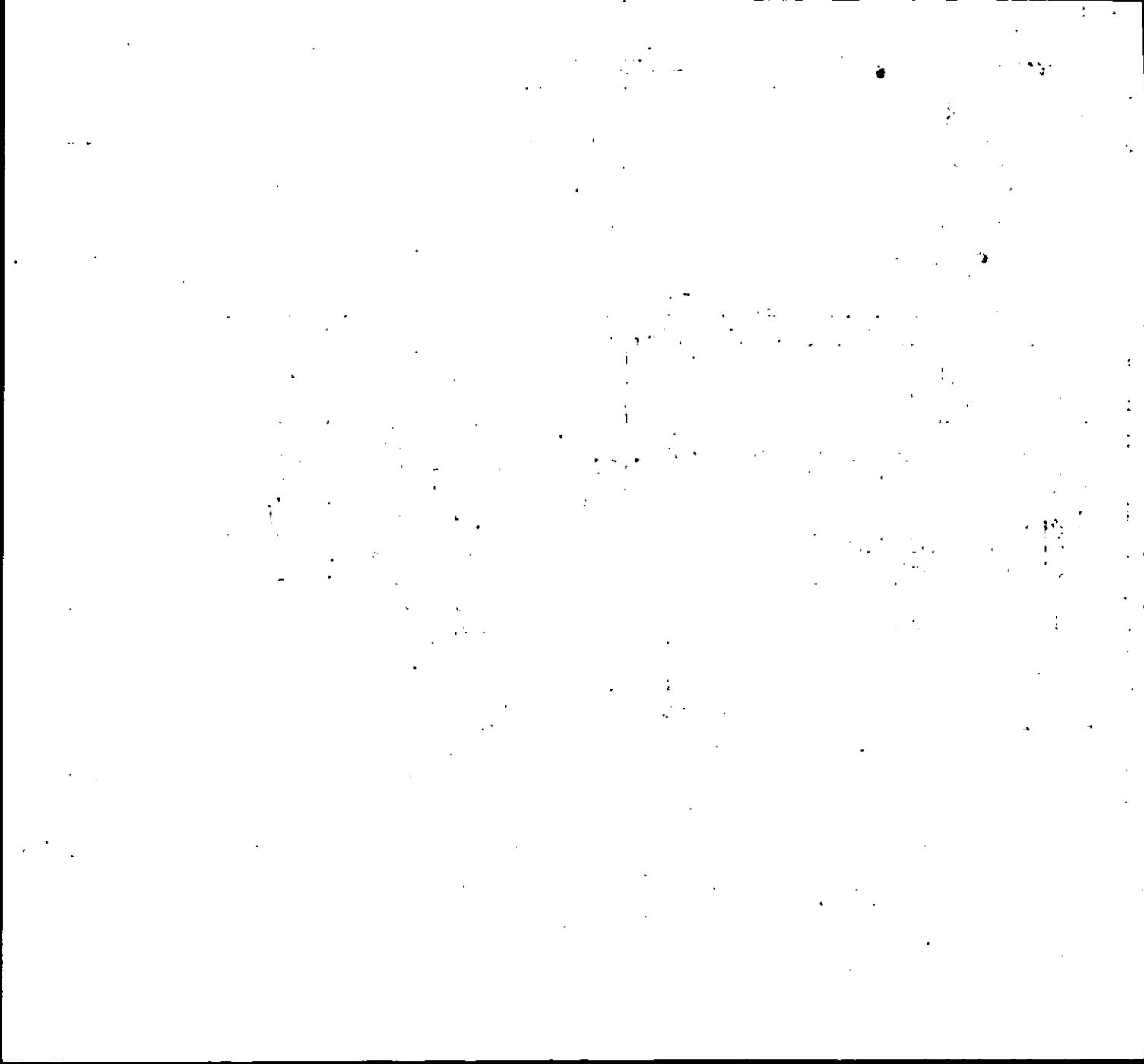
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?

Where did injury occur?

Manner of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify...
(Signed) J. P. Strickland, M. D.
(Address) Rockport, Missouri

Every item of information should be carefully supplied. AOB should be stated except where otherwise indicated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

9985-
Do not use this space.

1. PLACE OF DEATH
(a) County Atchison Registration District No. 19
(b) Township..... Primary Registration District No. 4013 Registered No.....
(c) City Rockport (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Gerald A. Wagner
(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 1938
7. AGE YEARS MONTHS DAYS 33 about 1 hr. 10 min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Data deceased last worked at this occupation (month and year).....
11. Total time (years) spent in this occupation.....
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE
19. FUNERAL DIRECTOR (ADDRESS)
20. FILED 19

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-5-1938
22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...
I last saw h... alive on... 19... Death is said to have occurred on the date stated above, at... m.
The principal cause of death and related causes of importance were as follows:
The baby was toxic most probably as the result of the mother having during pregnancy severe respiratory disease at birth.
Other contributory causes of importance:
and poorly developed
Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19...
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....
24. Was disease or injury in any way related to occupation of deceased?
If so, specify W. P. Strickland, M. D.
(Signed) Rockport (Address) ms

SUPPLEMENTARY

The baby was born in the home of Mrs. R. Strickland and I believe...

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

