

REC'D JUN 8 1938

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

17854  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Law Primary Registration District No. 1002  
(c) City MO (d) Street No. 110 Gen Hosp Registered No. 2256  
(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

(a) Residence, No. 1406 Locust 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) Inf.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-25-39

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 3 hrs. or 3 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. 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) MO

13. NAME Chas Wagoner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

15. MAIDEN NAME Betha Hessler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

17. INFORMANT (ADDRESS) Record Clerk

18. BURIAL, CREMATION, OR REMOVAL PLACE Gen Hosp DATE 5-29-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Peter B. Campbell  
336 Campbell St.

20. FILED May 31 1939 M. M. Brown  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-25-39

22. I HEREBY CERTIFY, That I attended deceased from 5-25-39, 1939, to 5-25, 1939

I last saw he alive on 5-25, 1939 Death is said

to have occurred on the date stated above, at 11:30 AM

The principal cause of death and related causes of importance were as follows:

Brain contusion  
and congestion  
of all organs  
Other contributory causes of importance: 160's

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1939

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 \_\_\_\_\_

(Signed) P. H. De Maria M. D.  
(Address) 1107 C. Gen Hosp

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**