

FILED FEB 7 1940

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

2877

Do not use this space.

## 1. PLACE OF DEATH

(a) County Lafayette 7 Registration District No. 454  
 (b) Township Middleton 0 Primary Registration District No. 5620A Registered No. 3  
 (c) City Alma Mo. (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

56 Wilhelm Ferdinand Jacob 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sophia Wagner  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-30-1865  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
74 4 15  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Janitor  
 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) Brentsville  
St. Clair Co., Ill.  
 FATHER 13. NAME Gustav Wagner  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany  
 MOTHER 15. MAIDEN NAME Dorothy Ferling  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brentsville  
St. Clair Co., Ill.  
 17. INFORMANT (ADDRESS) Chas. E. Wagner  
Alma Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Alma Int. Cem. DATE 1-17-1940  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. H. Brewer  
Alma Mo.  
 20. FILED Jan 16 1940 Mrs. E. O. McClure  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-15-1940  
 22. I HEREBY CERTIFY, That I attended deceased from 11-1-, 1929, to 1-14-, 1940  
 I last saw him alive on 1-14-, 1940. Death is said to have occurred on the date stated above, at 10 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Subdural Bleed  
1178  
 Other contributory causes of importance:  
Enlarged Heart  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical Was there an autopsy? No  
 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? No  
 If so, specify \_\_\_\_\_  
 (Signed) J. S. W. Fisher, M. D.  
 (Address) Alma, Mo.

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,

*A. H. Brewster*

, or by

Registered Apprentice No. ~~7676~~

, working under my personal supervision.

Signed

*A. H. Brewster*

Licensed Embalmer No. *- 7696*

P. O. Address *Alena, Md*

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.

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.

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

3877 Do not use this space.

1. PLACE OF DEATH (a) County Lafayette (b) Township Mableton (c) City (d) Street No. (e) Length of residence in city or town where death occurred (f) How long in U.S., if of foreign birth? 2. PRINT FULL NAME (a) Residence, No. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or 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) 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 Jan 16 1940 Mrs Frank McClure Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-16-1940 22. I HEREBY CERTIFY, That I attended deceased from ... to ... I last saw him ... 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: Date of onset Other contributory causes of importance: 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 (Signed) J. J. W. Fischer M. D. (Address) Alma mo

SUPPLEMENTARY

