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

FILED FEB 12 1940

3452
Do not use this space.

1. PLACE OF DEATH
(a) County Ralls (b) Township Spencer (c) City or Village U.S. Highway - #61
Registration District No. 726 Primary Registration District No. 5057
Registered No.
(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 Phillip A. Wagner
(a) Residence, No. 5908 Cates Ave. St. Louis - Mo. St.
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (~~OR WIFE OF~~) Ricka Wagner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About - 35			

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salesman
9. Industry or business in which work was done, as saw mill, bank, etc. Funeral Home Supplies
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) Minn.

FATHER
13. NAME John [redacted] Wagner
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Anna [redacted]
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Minn.

17. INFORMANT (ADDRESS) Ricka Wagner.

18. ~~BURIAL, CREMATION, OR~~ REMOVAL
PLACE St. Paul - Minn. DATE Jan - 3 1940

19. FUNERAL DIRECTOR (NAME) O'Donnell Funeral Home
(ADDRESS) New London - Mo.

20. FILED Feb 7 1940 Blondine Negary Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 2 1940

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 6:00 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Unavoidable auto Accident.	

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? Accident Date of injury 1/2, 1940
Where did injury occur? Ralls County, Mo. (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. U.S. Highway #61
Manner of injury .....
Nature of injury Skull fracture.

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify .....

(Signed) Clyde C. Wilbur Coroner
(Address) Perry, Mo. Ralls County

(Licensed Embalmer's Statement on Reverse Side)

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.

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RECEIVED
District Health Officer No. 10
District File Number 2-40-359
Date Filed FEB 9 1940

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 com with the above constitutes grounds for revocation of license.)

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

3452
Do not use this space.

1. PLACE OF DEATH
(a) County Ralls — Registration District No. 726
(b) Township Spencer — Primary Registration District No. 5957 — Registered No.
(c) City — (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 Phillip Wagner
(a) Residence, No. — St.
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
aft	35			

OCCUPATION
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Un known

MOTHER
15. MAIDEN NAME Anna —
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE ....19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 3 1940 Blanche Negown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1 1940

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:

	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) Clyde C Wilson M. D.
(Address) Perry Mo.

SUPPLEMENTARY

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.

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

WHITE PAPER X12241

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

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Do not use this space.

1. PLACE OF DEATH
(a) County Ralls — Registration District No. 226
(b) Township Spencer — Primary Registration District No. 595-7 — Registered No.
(c) City — (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 Phillip a Wagner

(a) Residence, No. — St. [ ]
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
m	w	m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
aff 38			

OCCUPATION
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 3 1940

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:

	Date of onset
Unavoidable accident	
Collision with other Motor Vehicle	

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) Clyde C. Wilsey Coroner
(Address) Perry Mo

SUPPLEMENTARY

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

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.