FILED SEP 16 1940

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

1. PLACE OF DEATH
County ~~Ste~~ Cape Girardeau Registration District No. 9 125 File No. 28180
Township Primary Registration District No. 3009 Registered No. 296
City Cape Girardeau (No. St. Ward)

2. FULL NAME 25th Charlotte Joan Wagoner
(a) Residence. No. Painton RFD St. Mo Ward. PAINTON Mo
(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: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): child.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: child.
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Febr 8-1940
7. AGE: — YEARS: — MONTHS: 6 DAYS: 24. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: child.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (CITY OR TOWN): Painton
(STATE OR COUNTRY): Stoddard Mo.

PARENTS
10. NAME OF FATHER: Donald Wagoner
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Blodgett
(STATE OR COUNTRY): Scott County Mo
12. MAIDEN NAME OF MOTHER: Hortance Shore
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Painton
(STATE OR COUNTRY): Scott County Missouri

14. INFORMANT: Donald Wagoner
(Address): ~~Cape~~ Painton Mo
15. FILED 9-2-40 J. M. Thompson
121 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9-2-1940
17. I HEREBY CERTIFY, That I attended deceased from 8-26-40, 19..., to 9-2, 1940, that I last saw her alive on 9-2, 1940 and that death occurred, on the date stated above, at 8 p. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Vincents Angina
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (SECONDARY): Muco-Colitis
(duration) yrs. mos. 10 ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) [signature], M. D
, 19 (Address) Cape Girardeau 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Malden Mo.
DATE OF BURIAL: Sept 4 1940
20. UNDERTAKER: P. S. Keisserer Co.
ADDRESS: Oran Mo

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.

LOCAL REGISTRAR'S REPORT DO NOT TEAR OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... ..... St. .....Ward)

2. FULL NAME .....

(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	4. COLOR OR RACE	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)

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19.....
that I last saw h....., alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(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)....., M. D

, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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