

FILED MAY 9 1941

STANDARD CERTIFICATE OF DEATH

State File No.

15742

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 743

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 23 hrs. 50 min.  
(Specify whether  
In this community live  
years, months or days)

3. (a) PRINT FULL NAME C. William Wagner

3. (b) If veteran, name war unknown  
3. (c) Social Security No. none

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ida Wagner  
6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Feb. 14 1890  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
51 1 21 hr. min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business

MOTHER FATHER { 12. Name William Wagner  
13. Birthplace St. Louis County Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Louise Bottner  
15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Wagner  
(b) Address Olivette Mo.

17. (a) Burial (b) Date thereof 4-7-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Samuel Luth. Cem.

18. (a) Signature of funeral director Baumann Bros. Inc.

(b) Address 2504 W. Woodson Rd. Overland Mo.

19. (a) APR 5 1941 (b) J. H. Meyer, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
(c) City or town Olivette  
(If outside city or town limits, write "RURAL")  
(d) Street No. 860 Dielman Rd.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 4  
year 1941 hour 4 minute 20 P. M.

21. I hereby certify that I attended the deceased from 4-3-41  
to 4-4-41  
that I last saw him im alive on 4-4-41  
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial insufficiency  
Duration 48 hr.

Due to degenerative heart disease 2 yrs.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93d  
Of autopsy

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (e) Means of injury

23. Signature H. H. Foreman Jr. (M. D. 4/5/41)

Address 20 St. ... Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 Oscar F. Mueller

Licensed Embalmer No. 3039

P. O. Address Overland Mo.

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

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 784

Primary Registration District No. 101

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County St Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Charles Wm Wagner

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 51 Months 1 Days 21 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 4-5-4 (b) J R Wagner M.D.P.A. (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH 1944 Month apr day 4  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J N Jarman Jr (M. D. or other) \_\_\_\_\_

Address 20 North Date signed \_\_\_\_\_

SUPPLEMENTARY

101

S-15742