No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 10 1941

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 27840

Registrar's No. 831

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

1. PLACE OF DEATH:
(a) County: BUCHANAN
(b) City or town: ST. JOSEPH (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL No. 2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-10-41 to 8-17-41 (Specify whether years, months or days)
In this community Admitted 4-10-1941

2. USUAL RESIDENCE OF DEACESED:
(a) State: Mo (b) County: Jackson
(c) City or town: Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 613 Bales Ave. (If rural, give location)
(e) If foreign born, how long in U. S. A.? O.K. years.

3. (a) PRINT FULL NAME: ROBERT WAGNER
3. (b) If veteran, name war: no
3. (c) Social Security No. NONE
4. Sex: MALE
5. Color or race: W
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Jan (Month) 23 (Day) 1884. (Year)
8. AGE: Years 57 Months 6 Days 24 If less than one day hr. min.
9. Birthplace: Nebraska (City, town, or county) (State or foreign country)
10. Usual occupation: Hotel clerk
11. Industry or business:
FATHER 12. Name: Abe wagner
13. Birthplace: Switzerland (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: D.K.
15. Birthplace: D.K. (City, town, or county) (State or foreign country)
16. (a) Informant: Admission Papers
(b) Address: State Hosp. #2 St. Joseph
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 20-1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Aspen Cem.
18. (a) Signature of funeral director: J. L. Kingsley
(b) Address: 1929 S. Michigan Ave
19. (a) Aug 21-1941 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17 year 1941 hour 12 minute A. M.
21. I hereby certify that I attended the deceased from April 10th 1941, to Aug 17th 1941, that I last saw alive on Aug 17th 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	?
Due to	
Due to Syphilitic Heart Disease	?
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy —	

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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: None
23. Signature: J. R. Bunch (M. D.)
Address: State Hospital #2 Date signed 8-17-41

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

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 wi the above constitutes grounds for revocation of license.)

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