

No. 2
-1-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30787**
3544
Registrar's No.

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K. C. General Hospital /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 mo. 7 days**
(Specify whether)
 In this community **23 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson** **48**
 (c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL")
1525 Cherry St. **8**
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **MARGARET A. WAGNER**

3. (b) If veteran, name war **XX** 3. (c) Social Security No. **None**

4. Sex **Fe /** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Joseph Wagner** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. **August 30 1853**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	88	0	20	hr. _____ min.

9. Birthplace **Farmington / Iowa**
(City, town, or county) (State or foreign country)
housewife

10. Usual occupation _____

11. Industry or business **At Home**

12. Name **Nicholas Rockelman**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **No Record**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Grover O. Wagner**

(b) Address **1525 Cherry**

17. (a) **Removal** (b) Date thereof **9-22-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Quincy, Illinois**

18. (a) Signature of funeral director **M. M. Crow**

(b) Address **Kansas City, Missouri**

19. (a) **9/22/41** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **20** 19**41**
year _____ hour _____ minute _____ M.

21. I hereby certify that I examined the deceased from _____ to _____
that **he** was **alive** on _____ and **that** death occurred on the date and hour stated above.

Immediate cause of death **Senility**
Duration _____

Due to **United pneumonic interbacterial**

Due to **fracture of left femur due to fall**

Other conditions **to fall**
(Include pregnancy within 3 months of death)

Major findings: Of operations **186 a 1/2**

Of autopsy **90 39**

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) **no not known**

(b) Date of occurrence **6-28-41**

(c) Where did injury occur? **K. C. Mo / 23**
(City or town) (County) (State)

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

While at work **Yes** (Specify type of place) (Specify nature of injury)

23. Signature **W. L. ...** (M. D. or other) **3**

Address **K. C. Mo.** Date signed _____

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

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 A. R. Hauschild

Licensed Embalmer No. 4159

P. O. Address Kansas City Mo

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, fact should be so stated above.