

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10878

FILED APR 24 1942

State File No. _____

Registration District No. 383

Primary Registration District No. 5473

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town Eagleville Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Hamilton Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether)
In this community 50 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 041
(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 0

3. (a) PRINT FULL NAME Jacob S. Waggoner
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29th
year 1942 hour 9:00 minute P. M.
21. I hereby certify that I attended the deceased from March-29th
1942 to March-29 1942
that I last saw h. in alive on March-29th 1942
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 11 1863
(Month) (Day) (Year)

Immediate cause of death: Hypostatic Pneumonia
due Acute Myocardial Failure.

8. AGE: Years 78 Months 7 Days 18
If less than one day hr. min.

Due to Cardio-Vascular-Renal disease??

9. Birthplace Muscataine Iowa
(City, town, or county) (State or foreign country)

Due to Secondary - Chronic interstitial Nephritis with uremia

10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death) uremia

11. Industry or business Stock raising

Major findings: Of operations _____

12. Name Daniel Wagner

Of autopsy 1310

13. Birthplace Do not know IA
(City, town, or county) (State or foreign country)

14. Maiden name Do not know

15. Birthplace " " " IA
(City, town, or county) (State or foreign country)

16. (a) Informant Ray Schaefer
(b) Address Eagleville Mo.

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? _____

17. (a) Burial (Burial, cremation or removal) (b) Date thereof April 1942
(Month) (Day) (Year)
(c) Place: burial or cremation Masonic Cemetery

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

18. (a) Signature of funeral director S. M. Haase
(b) Address Bethany Mo.

23. Signature Bill McCartney (M.D. or other) DO.
Address Eagleville - Mo. Date signed Apr 42

19. (a) 4-2 1942 (Date received local registrar) (b) Chas. Arthur (Registrar's signature)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

390

1120 (Licensed Embalmer's Statement on Reverse Side)

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 complete the above constitutes grounds for revocation of license.)

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

Registration District No. 337

Primary Registration District No. 5473

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Harrison

(b) City or town Rural
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Harrison

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(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 Jacob S Wagner

3. (b) If veteran name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, that I last saw him _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

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

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

7. Birth date of deceased Aug 11 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>7</u>	<u>18</u>	_____ min.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

Major findings: _____

Of operations _____

Of autopsy _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-2-1942 (b) Chas Adair
(Date received local registrar) (Registrar's signature)

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? _____

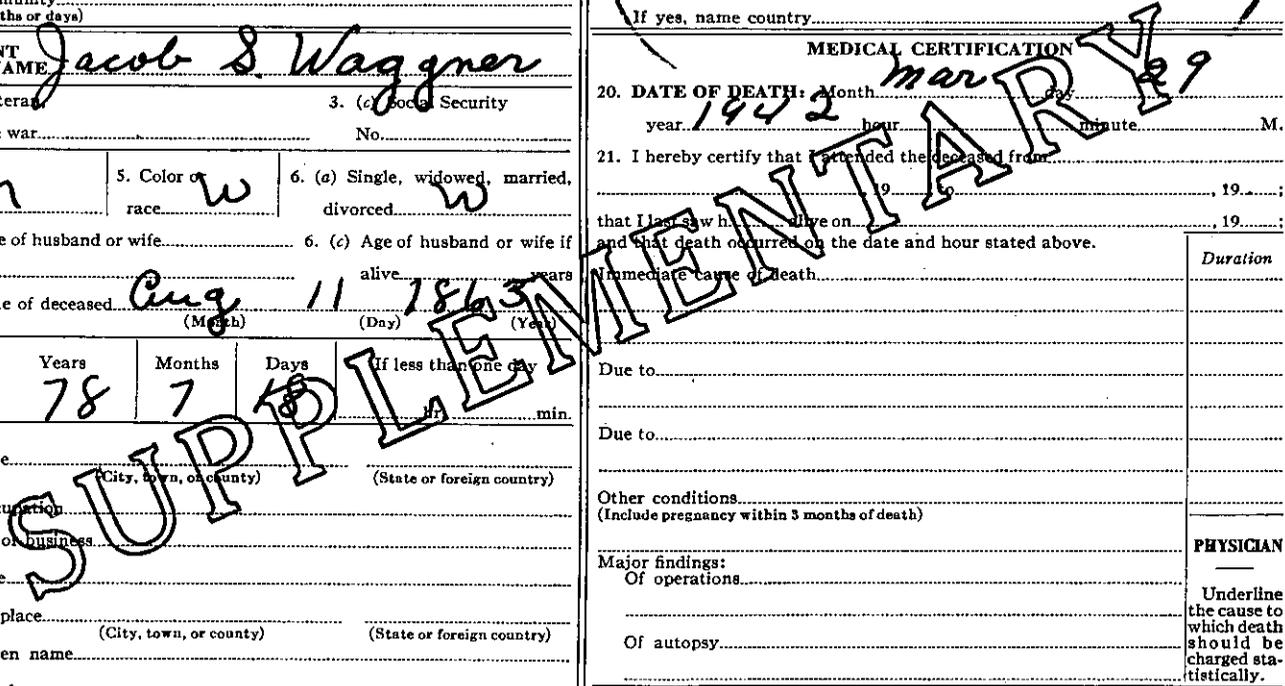
While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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



Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

S-10878

1942