

LED APR 8 1943

Registration District No. 439

Primary Registration District No. 4775

State File No. _____

Registrar's No. 20

1. PLACE OF DEATH:
(a) County Holt
(b) City or town Oregon
(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 3 weeks (Specify whether)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Holt
(c) City or town Oregon
(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 _____

3. (a) PRINT FULL NAME James Paul Wagner

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

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced. 0

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

7. Birth date of deceased. March 2 1937
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 12 _____ hr. _____ min.

9. Birthplace Burlington Junction Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Fletcher W. Wagner

13. Birthplace Nodaway County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Marie Pitts

15. Birthplace Burlington Junction Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Fletcher Wagner

(b) Address Oregon, Mo.

17. (a) Burial (b) Date thereof 3-17-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oregon, Missouri

18. (a) Signature of funeral director James H. Pettigrove

(b) Address Oregon Mo.

19. (a) 3-17-43 (b) Pauline Dawson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14
year 1943 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from March
13, 1943, to March 14, 1943
that I last saw him alive on March 14, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death, Acute intestinal 1 day
Duration

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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 Nelle D. Turney (M.D. or other) DO

Address Oregon, Mo. Date signed 3-14-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1185

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.....

James H Pettigrew
.....
Licensed Embalmer No. *3192*
.....
P. O. Address *Oregon 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10368
Registrar's No. 20

Registration District No. 139

Primary Registration District No. 4226

1. PLACE OF DEATH:

(a) County Healt
(b) City or town Oregon
(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..... (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.....

3. (a) PRINT FULL NAME James Paul 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.....

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

7. Birth date of deceased March 2 1943
(Month) (Day) (Year)

8. AGE: Years 6 Months - Days - (If less than one day..... min.

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

10. Usual occupation

11. Industry of 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1943 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 acute intestinal obstruction 1 day

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 1222

Major findings: Of operations

Of autopsy

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

MOTHER FATHER

SUPPLEMENTARY

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

