

FILED FEB 3 1944
Registration District No. **749**

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:
700 WEST 48TH STREET / APT. #103
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **13 YEARS**
years, months or days

3. (a) PRINT FULL NAME **MR. CHARLES S. WAGNER**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **486-10-6547**

4. Sex **MALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **MRS. WRETHA WAGNER**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **AUGUST 8 - 1888**
(Month) (Day) (Year)

8. AGE: Years **55** Months **5** Days **9**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **DISTRICT MANAGER**

11. Industry or business **PITTSBURG WATER HEATER**

12. Name **WILLIAM WAGNER**

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

14. Maiden name **ELLEN SIEGENTOS**

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

16. (a) Informant **MRS. WRETHA WAGNER**

(b) Address **700 WEST 48TH STREET**

17. (a) **BURIAL** (b) Date thereof **JAN. 20 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT. MORIAH CEM.**

18. (a) Signature of funeral director **D. N. Helcomer's Son**

(b) Address **1401 BRUSH GREEN BLVD.**

19. (a) **Jan 18, 1944** (b) **J. B. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **JACKSON**
(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
(d) Street No. **700 WEST 48TH STREET - APT. #103**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **JAN.** day **17TH**
year **1944** hour **9** minute **44** A. M.

21. I hereby certify that I attended the deceased from **Jan 16**
_____, 19**44**, to **Jan 17**, 19**44**.
that I last saw him alive on **Jan 16**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion 12 hrs.**
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 **M. Belmeiter** (M. D. or other)
Address **436 Professional Bldg.** Date signed **1-17-44**

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

2
-43
-39
C35697

2-4-30 PM

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..... *H. C. Newcomer Jr.*

Licensed Embalmer No..... *5049*

P. O. Address..... *H. C. Newcomer Jr.*

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.