

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18618**
Registration District No. **207**
Primary Registration District No. **4318**
Registrar's No. **59**

1. PLACE OF DEATH:

(a) County **Maries**
(b) City or town **Vienna, Mo.**
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Herschel Wagner**

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

4. Sex **male** 5. Color **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Clara Wagner** 6. (c) Age of husband or wife if alive **38** years

7. Birth date of deceased **3 13 1896**
(Month) (Day) (Year)

8. AGE: Years **48** Months **I** Days **7** If less than one day hr. min.

9. Birthplace **Pike County Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

12. Name **Alfred C. Wagner**
13. Birthplace **Pike County Ill.**
(City, town, or county) (State or foreign country)

14. Maiden name **Nora Pest**
15. Birthplace **Christian Co. Ill.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles Wagner**
(b) Address **Vienna, Mo.**

17. (a) **Burial** (b) Date thereof **4 22 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter's**

18. (a) Signature of funeral director **W.C. Birmingham**
(b) Address **Vienna, Mo.**

19. (a) **5-4-44** (b) **Erma Bassett**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Maries**
(c) City or town **Vienna, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **20**, 19**44**
year **8** hour **40** minute **P.M.**

21. I hereby certify that I attended the deceased from **December 20**, 19**43**, to **April 20**, 19**44**;

that I last saw him alive on **April 20**, 19**44**, and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Nephritis** Duration **1**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **ADDITIONAL SUPPLEMENTARY INFORMATION**
Of autopsy **INTERESTED**

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? _____

(Specify type of place) While at work? _____ (e) Means of injury **2**

23. Signature **W.C. Birmingham** (M. D. or other) **D.O.**
Address **Vienna, Mo.** Date signed **5/2/44**

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 5-15-44

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. 3664

P. O. Address Cheney, 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, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *June 59*
Registrar's No. _____

Registration District No. *207*

Primary Registration District No. *4318*

1. PLACE OF DEATH:

(a) County *maric*
(b) City or town *Uesing*
(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)

3. (a) PRINT
FULL NAME

Herschel 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 *m*

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

7. Birth date of deceased *march 13 1944*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.
48 1

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

10. Usual occupation

11. Industry or 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)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* 21. I hereby certify that I attended the deceased from *1944* year *1944* hour minute M.

21. I hereby certify that I attended the deceased from *1944* year *1944* hour minute M.
that I last saw him alive on *1944* year *1944* month *April* day *13* and that death occurred on the date and hour stated above.
Immediate cause of death *acute nephritis* Duration

Due to *Chronic nephritis*
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?

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

23. Signature (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

18618