

FILED JUL 24 1944

Registration District No.

Primary Registration District No. 4318

1. PLACE OF DEATH:

(a) County Maries Mo
(b) City or town Vienna, Mo.
(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 Alfred Casper 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 married
6. (b) Name of husband or wife Nora Wagner 6. (c) Age of husband or wife if alive 74 years II 1870
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 20 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name William Wagner

13. Birthplace Pike Co. Ill. (City, town or county) (State or foreign country)

14. Maiden name Laura Bider

15. Birthplace Pike Ill. (City, town or county) (State or foreign country)

16. (a) Informant Nora Wagner Vienna, Mo.

(b) Address

17. (a) Burial (b) Date thereof 6 2 44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rader Mo.

18. (a) Signature of funeral director W. C. Cunningham

(b) Address Vienna Mo.

19. (a) 7/1/44 (b) Erma Spett (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Maries 63
(c) City or town Vienna Mo. (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31 year 1944 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from March 19 1942 to May 30 1944
that I last saw him alive on May 30 1944
and that death occurred on the date and hour stated above

Immediate cause of death Cerebral work and exertion following prostate removal Duration

Due to senility

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 W. C. Cunningham (M. D. or other)

Address Vienna, Mo. Date signed 6/30/44

RECEIVED

District Health Officer No.

District File Number

Date Filed 7-21-44

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. 3644

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. aug
Registrar's No. 978

Registration District No. 207

Primary Registration District No. 4318

1. PLACE OF DEATH:

(a) County maria
(b) City or town Vienna
(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

Alfred C. 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

7. Birth date of deceased (Month) (Day) (Year)

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

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 may day 3
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
that I last saw him alive on
and that death occurred on the date and hour stated above.
Immediate cause of death ever worked Duration
exertion following
prostate removal

Due to senility 137a

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Prostatic Hypertrophy Underline the cause to which death should be charged statistically.

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 J. C. Howard (M. D. or other) MD

Address Vienna, Mo. Date signed 8/14/44

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

SUPPLEMENTARY

25163