

FILED NOV 10 1944
 Registration District No. **3948**

Primary Registration District No. **1003**

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

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1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital—Max C. Starkloff
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days Memorial
(Specify whether
 In this community 0
years, months or days)

3. (a) PRINT FULL NAME Roy Wagster
 3. (b) If veteran, name war None
 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 17 1903
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>41</u>	<u>8</u>	<u>14</u>	hr. _____ min.

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

10. Usual occupation Painter

11. Industry or business _____

MOTHER FATHER {
 12. Name Charles Wagster
 13. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)
 14. Maiden name Annie White
 15. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Annie Wagster
 (b) Address Cooter, Mo.

17. (a) Removal (b) Date thereof 11-2-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Havti, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.

19. (a) NOV 2 1944 (b) J. F. Budeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Pemiscot
 (c) City or town Cooter
(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 NOV. day 1st
 year 1944 hour 4:30 minute _____ M.

21. I hereby certify that I attended the deceased from 10/28/44
 _____, 19____, to NOV. 1st, 1944;

that I last saw him alive on Nov. 1st, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death 19 dilatation of heart due to pulmonary disease (Pulmonary artery arteriosclerosis)
 Duration _____
 Due to _____

Due to _____
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Other conditions Pericarditis with situs inversus, Emphysema, Bronchopneumonia
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____

Of autopsy As above.
 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 Hesbert C. Fritz (M. D. or other) _____
1315 Lafayette Date signed 11/2/44
 Address _____

NOV 28 1944

APR 7 1955

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..... *W W Wilkins*
Licensed Embalmer No..... 3575
P. O. Address.....

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.