V. S. No. 2
200M—8-43
Rev. 5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6270

Registration District No. 14 | Primary Registration District No. 3025 | Registrar's No. 19

1. PLACE OF DEATH:
(a) County HOWELL
(b) City or town WEST PLAINS (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 320 OAK STREET (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NO (Specify whether years, months or days)
In this community 6 1/2 MONTHS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County HOWELL
(c) City or town WEST PLAINS (If outside city or town limits, write "RURAL")
(d) Street No. 320 OAK STREET (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME SUSAN ELLEN WAGONER
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife JOHN WM. WAGONER
6. (c) Age of husband or wife if alive ___ years
7. Birth date of deceased DECEMBER (Month) 24, (Day) 1866 (Year)

8. AGE: Years	Months	Days	If less than one day
78	1	17	hr. min.

9. Birthplace MYATT TWP, HOWELL CO. (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation NONE
11. Industry or business

FATHER
12. Name LARKIN ALLEN
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name SARAH HILL
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant GROVER WAGONER
(b) Address WEST PLAINS, MO., LANTON RT
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 2-12-45 (Month) (Day) (Year)
(c) Place: burial or cremation STATE LINE CEM. ARKANSAS
18. (a) Signature of funeral director H. C. Thornburgh
(b) Address WEST PLAINS, MO.
19. (a) 2/18-45 (Date received local registrar) (b) Pearl Fairless (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 11, year 1945 hour 8: minute 30 A. M.

21. I hereby certify that I attended the deceased from Feby 11 1945 to Feby 8 19 45 that I last saw her alive on ___ 19 ___ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Arterio Sclerosis
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations No
Of autopsy No

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 R. H. Vaughan M.D. (M.D. or other)
Address West Plains Mo Date signed 2/14/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No 5
District File Number 345128
Date Filed 3-5-45

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 Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.