

FILED JUL 17 1945

State File No. _____

Registration District No. 149

Primary Registration District No. 1001

Registrar's No. 2784

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: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 weeks
(Specify whether years, months or days)
In this community 40 yrs

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. 1640 Washington
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Emma Wagner

3. (b) If veteran, name war nu

3. (c) Social Security No. no

4. Sex fe 5. Color or race w
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Harry Wagner
6. (c) Age of husband or wife if alive 23 years
7. Birth date of deceased Aug 15 1895
(Month) (Day) (Year)

8. AGE: Years 49 Months 10 Days 16
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name Frank Miller
13. Birthplace Mass
(City, town, or county) (State or foreign country)
14. Maiden name Mary Mason
15. Birthplace Mich
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Wagner
(b) Address 1640 Washington
17. (a) Burial (b) Date thereof July - 5 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Marys

18. (a) Signature of funeral director Mr. C. Foster
(b) Address 918 Broadway
19. (a) 2-2-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1945 hour 3 minute 45 P. M.

21. I hereby certify that I attended the deceased from May 15 1945 to July 1 1945
that I last saw h. er alive on July 1 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____
rheumatic heart disease chronic
Due to cardiac decompensation
cerebral emboli

Other conditions _____
(Include pregnancy within 3 months of death) 95

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) (c) Means of injury _____
23. Signature Clark W Seely MD (M. D. or other)
Address Med. Dir. K.C. General Hospital Date signed _____

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

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. 2737

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.