

FILED JAN 14 1946 STANDARD CERTIFICATE OF DEATH

Registration District No. 120

Primary Registration District No. 4197

Registrar's No. 109

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Stamper, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 20 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Mrs. Minnie E. Wagers

(b) If veteran, name war ✓

(c) Social Security No. NONE

4. Sex Female
5. Color or race W.

6. (a) Single, widowed, married, divorced Widow
6. (c) Age of husband or wife if alive deceased years

(b) Name of husband or wife SAMUEL WAGERS

(c) Age of husband or wife if alive deceased years

7. Birth date of deceased Dec. 26 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 0 Days 4
If less than one day ✓ hr. ✓ min.

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

10. Usual occupation Housewife

11. Industry or business at Home

12. Name Mountain Ellis

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

14. Maiden name Dorcas Gate-bush

15. Birthplace Buckhorn, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Minnie Wagers
(b) Address Stamper, Mo

17. (a) (Burial, cremation, or removal) Stamper, Mo
(b) Date thereof Dec 29-1945
(Month) (Day) (Year)

(c) Place: burial or cremation Stamper, Mo

18. (a) Signature of funeral director Clayton Phillips
(b) Address Stamper, Mo

19. Dec 29-1945 (Data received local registrar) (b) Harold W. Mahan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
year 1945 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec 27, 1945 to Dec 27, 1945
that I last saw her alive on Dec 27, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Diabetic Coma
Diabetic Mellitus

Due to:

Due to:

Other conditions (Include pregnancy, within 3 months of death)

Major findings: Of operations: 61
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 Harold W. Mahan (M. D. or other)

Address Stamper, Mo Date signed 12/29/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1138

RECEIVED

District Health Officer No. 11,

District File Number _____

Date Filed _____

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, ~~only~~

~~working under my personal supervision.~~

Registered Apprentice No. _____

Signed

Leroy H. Phillips

Licensed Embalmer No. *1898*

P. O. Address *Stonewall 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.