

S. No. 2  
M-2-43  
5-17-39  
X35097

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 25 1946**  
STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **7185**  
Registrar's No. **422**

Registration District No. **317**  
Primary Registration District No. **6676**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **So. Kinloch**  
(c) Name of hospital or institution: **Little near Carson**  
(d) Length of stay: In hospital or institution **6 yrs.**  
In this community **6 yrs.**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **St. Louis Co.**  
(c) City or town **So. Kinloch**  
(d) Street No. **Little near Carson**  
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **ALBERT WAGNER**  
3. (b) If veteran, name war **—**  
3. (c) Social Security No. **—**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **2** day **16**  
year **1946** hour **22** minute **15 A.M.**  
21. I hereby certify that I attended the deceased from **5-9-46**  
to **2-16-46**  
that I last saw him alive on **2-14-46**  
and that death occurred on the date and hour stated above.

4. Sex **MALE**  
5. Color or race **Negro**  
6. (a) Single, widowed, married, divorced **MARRIED**  
6. (b) Name of husband or wife **PEARL WAGNER**  
6. (c) Age of husband or wife if alive **60** years  
7. Birth date of deceased: **5-26-1882**

Immediate cause of death **Chronic Interstitial hepatitis**  
Due to **1310**  
Other conditions **—**  
Major findings: Of operations **—**  
Of autopsy **—**

8. AGE: Years **64** Months **00** Days **17**  
9. Birthplace **O'FALLAN MO.**

Duration **Suppl 4 yrs**  
PHYSICIAN **—**  
Underline the cause to which death should be charged statistically.

10. Usual occupation **LABORER**  
11. Industry or business **—**  
12. Name **DAN WAGNER**  
13. Birthplace **O'Fallen MO.**  
14. Maiden name **PEARL WAGNER**  
15. Birthplace **O'Fallen MO.**  
16. (a) Informant **PEARL WAGNER**  
(b) Address **TUTTLE NEAR CARSON**  
17. (a) **BURIAL** (b) Date thereof **2-19-46**  
(c) Place: burial or cremation **Washington Park Cem.**  
18. (a) Signature of funeral director **Boyd Bros. Funeral Home**  
(b) Address **614 1/2 Park St. Kinloch**  
19. (a) **2-19-46** (b) **E. J. M. Langan M.D.**

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? **—**  
(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 **[Signature]** (f. D. or other) **—**  
Address **S. Kinloch Park Mo.** 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 *James A. Johnson*  
Licensed Embalmer No. *3522*  
P. O. Address *3704 Finney*

**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.**