

No. 2
2-45
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X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED 1946
STANDARD CERTIFICATE OF DEATH

35689

State File No.

Registration District No. **#62811318** Primary Registration District No.

1003

Registrar's No.

8743

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis, Missouri.**
(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
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County.....
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **3403 Lafayette** (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

REV. WILLIAM E. WAGNER

3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **9th**
year **1946** hour **11:20** minute **P** M.
21. I hereby certify that I attended the deceased from **9/19/46**
19..... to **Oct. 9th** 19 **46**
that I last saw him alive on **Oct. 9th** 19 **46**
and that death occurred on the date and hour stated above.

4. Sex **MO** 5. Color or race **W**
6. (a) Single, widowed, married, divorced, widower
6. (b) Name of husband or wife **Cecelia Wagner** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **12-9-1876**
(Month) (Day) (Year)

Immediate cause of death
Hemorrhage into basilar ganglia, rupture of basilar artery, hypertension
Due to.....
Due to.....
Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy **As above**

8. AGE: Years **69** Months **10** Days **0**
If less than one day hr. min.

9: Birthplace **unknown Ind!**
(City, town, or county) (State or foreign country)

10. Usual occupation **minister**

11. Industry or business **Charles Wagner**

12. Name **Charles Wagner**

13. Birthplace **Ind!**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Wendel**

15. Birthplace **Ind!**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dorothy Wagner**
(b) Address **5661 Labadie**

17. (a) **Cremation** (b) Date thereof **10-12-46**
(burial, cremation, or interment) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove**
18. (a) Signature of funeral director **Drehmann Board**
(b) Address **1905 Union Blvd**

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 work) Means of injury.....
23. Signature **W. F. Bredich** 15 Labadie
Address..... Date signed **10/10/46**
(M. D. or other)

19. (a) **OCT 11 1946** (Date received by registrar) **J. F. Bredich** (Registrar's signature)

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.....

Warren A. Carver

Licensed Embalmer No. *3534*

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.