

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43710

FILED JAN 20 1947
Registration District No. 367

Primary Registration District No. 6246

Registrar's No. 12

1. PLACE OF DEATH:

(a) County WASHINGTON
(b) City or town RURAL - Concord
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
NONE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NONE (Specify whether
In this community 20 YRS years, months or days)

3. (a) PRINT FULL NAME PUTH WAGNER
3. (b) If veteran, name war NO
3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife FRED ~~WAGNER~~ WAGNER
6. (c) Age of husband or wife if alive UNKNOWN years
7. Birth date of deceased UNKNOWN
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
UNKNOWN 7 UNKNOWN UNKNOWN min.

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

10. Usual occupation Nurse Work

11. Industry or business UNKNOWN

MOTHER FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN UNKNOWN
15. Birthplace UNKNOWN UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant ROBERT HONEA

(b) Address IRONDALE RR MO

17. (a) RURAL (b) Date thereof Jan 1 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BIG RIVER

18. (a) Signature of funeral director J.S. BOYER & SON

(b) Address LEAPWOOD MO

19. (a) 1-10-47 (b) Jessie Eichenberger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County WASHINGTON
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. NEAR IRONDALE MO
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31
year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from
Dec 15 - 1946 to Dec 31 - 1946
that I last saw her alive on Dec 15, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Multiple Cancer
Due to _____
Due to Unknown
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: 55E
Of operations _____
Of autopsy _____

Duration
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)
(e) Means of injury _____
23. Signature F.W. Gale (M. D. or other)
Address Bismarck MO Date 1-1-47

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

42517

REIVED

Health Officer No. 4
File Number 147-74
Filed 1-15-47

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.....

Not Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed

Bert L. Boyer

Licensed Embalmer No. 3445

P. O. Address Leadwood 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.