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5-17-39  
P 1 X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JUL 14 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **21235**  
**2843**  
Registrar's No. \_\_\_\_\_

Registration District No. **149**

Primary Registration District No. **1602**

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: **Conley Maternity Hospital**  
(If not in hospital or institution, write street number of location)  
(d) Length of stay: In hospital or institution **3 hrs.**  
In this community **3 hrs.**  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Livingston**  
(c) City or town **Chillicothe**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Gary Mark Wagaman**  
(b) If veteran, name war **no**  
(c) Social Security No. **none**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **7** day **2**  
year **1947** hour **8** minute **47P** M.  
21. I hereby certify that I attended the deceased from **7-2-47** 19... to **7-3-47** 19...  
that I last saw him alive on **7-2-47** 19...  
and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **W**  
6. (a) Single, widowed, married, divorced **single**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **July 1 1947**  
(Month) (Day) (Year)  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days **1 14** hr. \_\_\_\_\_ min.

Immediate cause of death **Atelectasis**  
Due to **Prematurity**  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) **159**  
Major findings: Of operations \_\_\_\_\_  
Of autopsy **atelectasis of complete right lung & of lower lobe of left lung**

9. Birthplace **Chillicothe Mo.**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **infant**  
11. Industry or business \_\_\_\_\_  
12. Name **Hastings Mark Wagaman**  
13. Birthplace **Bogard Mo.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Lena Lois Shannon**  
15. Birthplace **Hale Mo.**  
(City, town, or county) (State or foreign country)  
16. (a) Informant **H. M. Wagaman**  
(b) Address **Chillicothe Mo.**  
17. (a) **Removal** (b) Date thereof **7-2-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Bogard Mo.**  
18. (a) Signature of funeral director **Mrs. E. L. Foster**  
(b) Address **918 Brooklyn, K.C., Mo.**  
19. (a) **7-3-47** **Sheraldine Holmes**  
(Date received local registrar) (Registrar's signature)

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 **Lee E. Davidson** (M. D. or other) **DO**  
Address **2105 Independence Ave** Date signed **7-3-47**

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

MOTHER FATHER

**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 Dean Owens

Licensed Embalmer No. 4280

P. O. Address 918 Brooklyn  
K. C., 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.**