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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23816

Registration District No. 7 Primary Registration District No. 4167 Registrar's No. 18

1. PLACE OF DEATH:
(a) County DeKalb
(b) City or town Amity
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 50 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County DeKalb 32
(c) City or town Amity 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Robert Irving Wagers
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced (write) M
6. (b) Name of husband or wife Lucy Ann Wagers
6. (c) Age of husband or wife if alive 81 years
7. Date of death: June (Month) 26 (Day) 1857 (Year)

8. AGE: Years 90 Months 0 Days 4 If less than one day hr. min.

9. Birthplace Estill Co. Ken. (City, town, or county) (State or foreign country)
10. Usual occupation FARMER
11. Industry or business

FATHER
12. Name James Wagers
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nellie Thompson
(b) Address Amity Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-47 (Month) (Day) (Year)
(c) Place: burial or cremation Amity Mo.
18. (a) Signature Undertaker or agent Fisher Funeral Home
(b) Address Maysville Mo
19. (a) 7-2-47 (Date received local registrar) (b) R Landon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 1947 hour 9 minute 30 A.M.
21. I hereby certify that I attended the deceased from May, 19 42 to June 30, 19 47
that I last saw him alive on June 30, 19 47
and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death: Senility	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature M.D. Harold Fowler M.D. or other)
Address Maysville Mo Date signed 7-2-47

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Neal R. Lawson, Registered Apprentice No. 484, working under my personal supervision.

Signed L. Silcox

Licensed Embalmer No. 3960

P. O. Address Maysville 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.