

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36571

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25202

FILED AUG 9 1947

Registration District No. 314

Primary Registration District No. 6064

Registrar's No.

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

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Osceola (Rural)  
(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 42 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ira Waggle

3. (b) If veteran No name war

3. (c) Social Security No

4. Sex Male race White

5. Color White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Elizabeth Waggle

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased January 10 1877  
(Month) (Day) (Year)

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

70 5 14 hr. min.

9. Birthplace Beatress Nebraska  
(City or town) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name William W. Waggle

13. Birthplace Illinois  
(City or town) (State or foreign country)

14. Maiden name Martha E. Dixon

15. Birthplace Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Elmer Waggle

(b) Address Osceola Missouri

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 6-26-47  
(Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Mound Cemetery

18. (a) Signature of funeral director F.E. Goodrich

(b) Address Osceola Missouri

19. (a) 7-1-47 (Date received local registrar)

(b) Paul H. Seever (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

(c) City or town Osceola Missouri  
(If outside city or town limits, write "RURAL")

(d) Street No. 1 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24  
year 1947 hour 2 minute 20 P.M.

21. I hereby certify that I attended the deceased from 6-23 1947 to 6-24 1947  
that I last saw him alive on 6-24 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction

Duration about 1 hour

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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?

23. Signature Paul H. Seever (M. D. or other)  
Address Osceola Mo Date signed 6-25-47

RECEIVED  
District Health Officer No. 7,  
7-47-916  
8-8-47  
Date Filed

JUN 23 1948

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 J. B. Goodrich  
Licensed Embalmer No. 3038  
P. O. Address Oreover 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.