. No. 2
—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 8 1948

Registration District No. 238

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5821

State File No. 42472

Registrar's No. 256

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town R.F.D. Sikeston
(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 4 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Scott 100
(c) City or town Sikeston Rural
(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 EDWARD WAGNER
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ✓
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Dec (Month) 10 (Day) 1919 (Year)

8. AGE: Years 27 Months 11 Days 6 If less than one day ..... hr. ..... min.

9. Birthplace Mc Cracken (City, town, or county) Co. Ky. (State or foreign country)
10. Usual occupation Farm Labor
11. Industry or business
MOTHER FATHER
12. Name Harrison Wagner
13. Birthplace Ballard (City, town, or county) Co. Ky. (State or foreign country)
14. Maiden name Viola Caffee
15. Birthplace Ballard (City, town, or county) Co. Ky. (State or foreign country)
16. (a) Informant Harrison Wagner
(b) Address R.F.D. Sikeston Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/47 (Month) (Day) (Year)
(c) Place: burial or cremation Carpenter Cemetery
18. (a) Signature of funeral director Welch Funeral Home
(b) Address Sikeston Mo.
19. (a) 12-16-47 (Date received local registrar) (b) Helen Lord Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16
year 1947 hour 3 minute 20 A. M.
21. I hereby certify that I attended the deceased from 3
9-15, 1947, to 11-16, 1947,
that I last saw him alive on 11-16, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Failure
Due to Hypostatic Pneumonia
Due to Extensive third Degree Burns
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) 100
(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 0
23. Signature Alden P. Sargent (M. D. or other) M.D.
Address Sikeston, Mo. Date signed 11-29-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 148-31
Date Filed 1-5-48

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.

6. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan 256

Registration District No. 238 Primary Registration District No. 5821 Registrar's No. 256

1. PLACE OF DEATH:

(a) County New Madrid

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Edward Wagner

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 10 1917 (Month) (Day) (Year)

8. AGE: Years 27 Months 1 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day Year 1947 Hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Died of Hypostatic Pneumonia

Due to do not know when he was burned!

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY 56

The man died of pneumonia of Hypostatic character - I don't know when he was burned - but it happened at his home somewhere in Kentucky during the late winter or early spring of 1947

A. L. Sargent M.D.

42472