S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED FEB 10 1948

Registration District No. 1486

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3026

State File No. 1433

Registrar's No. 32

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 405 W. - St. Charles St.
(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: 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Independence
(If outside city or town limits, write "RURAL")
(d) Street No.: 405 W. - St. Charles
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Henry Frank Wagner
3. (b) If veteran, name war: No.
3. (c) Social Security No.: [illegible]

4. Sex: Male
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Minnie Wagner
6. (c) Age of husband or wife if alive, or if dead, how long: Dead years
7. Birth date of deceased: March (Month) 2 (Day) 1870 (Year)

8. AGE: Years	Months	Days	If less than one day
77	10	19	hr. ..... min.

9. Birthplace: Elizabeth (City, town, or county) Ky. (State or foreign country)
10. Usual occupation: Janitor
11. Industry or business: Bank

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

16. (a) Informant: Mrs. Lonnie Wagner
(b) Address: 414 W. - Mill St.
17. (a) Burial: (Burial, cremation, or removal) (b) Date thereof: Jan 22, 48 (Month) (Day) (Year)
(c) Place: burial or cremation: Woodlawn Cem.
18. (a) Signature of funeral director: Lee Davis
(b) Address: 1513 Troost Ave.
19. (a) 1-21-48 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19 year 48 hour 8 minute 30 A. M.
21. I hereby certify that I attended the deceased from July, 1946 to Jan. 19, 1948 and that I last saw him alive on Jan. 17, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Sepsis - Cystitis	2 mo
Due to: Carcinoma Prostate -	2 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: Transurethral Resection of prostate - 1946	
Of autopsy:	

PHYSICIAN — Underline the cause of 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: 0

23. Signature: J. C. Hickman (M. D. or other)
Address: Independence Mo. Date signed: Jan 26-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.