

FILED MAR 20 1948

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1003

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: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Weeks
(Specify whether years, months or days)
 In this community 2 Weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
 (c) City or town Marshall
(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 Jess Lee Waggoner

3. (b) If veteran, name war no 3. (c) Social Security No. unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lovey Dell Waggoner 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Aug. 4 1891
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>6</u>	<u>29</u>	hr. _____ min. _____

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

10. Usual occupation Welder

11. Industry or business _____

12. Name Frank Waggoner

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Laura Stewart

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

16. (a) Informant Dorothy Young

(b) Address Falls City Nebraska

17. (a) Removal (b) Date thereof Mar. 3, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Butler Missouri

18. (a) Signature of funeral director Mrs C.L. Forster

(b) Address 918 Brooklyn

19. (a) 3-3-48 (b) Deraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3rd.
 year 1948 hour 2 minute 40 A.M.

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

Immediate cause of death Intercranial Hemorrhage
from Injury 3rd Ventricle
(Brain tumor type involvement)
Internal Hydrocephalus
Lateral Ventricle

Duration

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: above

Of operations 5712

Of autopsy Above.

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? _____

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

23. Signature [Signature] (M, D, or other) _____
 Address St. Joseph Hospital Date signed 3/3/48

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

MOTHER FATHER

DEC 9 1932

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. 740.

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.