

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21948

FILED JUL 13 1948

Registration District No. 354

Primary Registration District No. 6201

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ilex as
 (b) City or town Saragat, Texas
 (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 Missouri (b) County Texas 107
 (c) City or town Star Route 10
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME John Henry Waggoner

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

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

6. (b) Name of husband or wife Francis Waggoner 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 26 1892
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 7 5 hr. _____ min.

9. Birthplace Willow Springs Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name George Waggoner

13. Birthplace Don't know
 (City, town, or county) (State or foreign country)

14. Maiden name Melissa Beazley

15. Birthplace Don't know
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ernie Waggoner

(b) Address Texas County

17. (a) burial (b) Date thereof 6/2/48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pine Grove Community

18. (a) Signature of funeral director DURNS

(b) Address Willow Springs, Missouri

19. (a) 6-1-48 (b) Gaynell Cunningham
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
 year 1948 hour 10:30 minute _____ A. M.

21. I hereby certify that I attended the deceased from 5-18- 1948 to 6-31- 1948;
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-Pneumonia 3 days
 Due to Cerebral Hemorrhage 10 days

Due to Hypertension

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

Major findings: Of operations _____
 Of autopsy _____

Duration
 3 days
 10 days
 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? _____ (c) Means of injury _____

23. Signature [Signature] (M. D. _____)
 Address Willow Springs Date signed 6/3/48

H. G. S. (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

X

JUL 13 1948

SEP - 29 - 1955

JUL 13 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.....

Fred W. Barnes

Registered Apprentice No. *413*

working under my personal supervision.

Signed *J. C. Burns*

Licensed Embalmer No. *3379*

P. O. Address *Willow Springs*

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.

Registration District No. 354 Primary Registration District No. 6201

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Sargent
(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 _____ years, months or days

3. (a) PRINT FULL NAME

John H. Waggoner
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 M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 26 1937 (Month) (Day) (Year)

8. AGE: Years 55 Months _____ Days _____ (If less than one day, hr. min.)

9. Birthplace _____ (City, town, or county) (State or foreign country) No

10. Usual occupation Farmer

11. Industry or business _____
12. Name George Waggoner
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Mississippi Beasley
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Coffee Waggoner
(b) Address 214 E 4th

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof 6/2-48 (Month) (Day) (Year)
(c) Place: burial or cremation Princeton Cem

18. (a) Signature of funeral director Burn
(b) Address Weldon Spring, Mo

19. (a) June 1 48 (Date received local registrar) (b) Raynell Cunningham (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas
(c) City or town Star Route Sargent Tex
(If outside city or town limits, write "RURAL" and name of township)
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death bronchitis pneumonia
Due to Cerebral Hemorrhage
Due to Hypertension
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

13880

S-21948