

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12749
Registrar's No. 1288

FILED APR 16 1949

BIRTH NO. 49-002357 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1802

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission). a. STATE MISSOURI		b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. LENGTH OF STAY (In this place) 2 months		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 1320 Spruce			
3. NAME OF DECEASED (Type or Print) a. (First) EARL		b. (Middle) LEON		c. (Last) WAGNER	
4. DATE OF DEATH (Month) (Day) (Year) MARCH 18 1949		5. SEX MALE		6. COLOR OR RACE NEGRO	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE		8. DATE OF BIRTH JANUARY 3 1949		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 2 1/2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) KANSAS CITY, MISSOURI	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME EARLIS WAGNER		13b. MOTHER'S MAIDEN NAME WADIE HAMPTON	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME WADIE WAGNER		ADDRESS 1320 Spruce			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death? I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) POST OPERATIVE INTESTINAL OBSTRUCTION (MECHANICAL) gauze sponge		INTERVAL BETWEEN ONSET AND DEATH		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. pyloric stenosis	
19a. DATE OF OPERATION 3/18/49		19b. MAJOR FINDINGS OF OPERATION 7520		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/21/1949 , to 3/18/39 , 19___, that I last saw the deceased alive on 3/18/49 , 19___, and that death occurred at 1:55P m., from the causes and on the date stated above.					
23a. SIGNATURE OF REGISTRAR Frank Elma		23b. ADDRESS 600 East 22nd Street		23c. DATE SIGNED 3/19/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 3/21/49		24c. NAME OF CEMETERY OR CREMATORY Lincoln	
24d. LOCATION (City, town, or county) (State) K.C. Mo		25. FUNERAL DIRECTOR'S SIGNATURE Jeanie L. Veach		ADDRESS 1708 E. 18	
DATE REC'D BY LOCAL REG. 3-21-49		REGISTRAR'S SIGNATURE M. Geraldine Holmea		25. FUNERAL DIRECTOR'S SIGNATURE Jeanie L. Veach	

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, ~~on~~

Student Embalmer No. _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed *Maynard C. Gilliam*

Licensed Embalmer No. *4653*

P. O. Address *1708 E 18 St. K. C.*

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.