S. No. 300
v. 10.48

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

FILED JUN 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20529

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2581

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City
c. LENGTH OF STAY (in this place) 2 WKS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Trinity Lutheran Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Bates
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Foster, Mo. 0070
d. STREET ADDRESS (If rural, give location) /

3. NAME OF DECEASED (Type or Print) a. (First) Bert b. (Middle) V. c. (Last) Wagner

4. DATE OF DEATH (Month) (Day) (Year) 6-7-50

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /
8. DATE OF BIRTH Aug. 31, 1876
9. AGE (In years last birthday) 73 — If under 1 year: Months, Days — If under 1 hr.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Boswell, Indiana /
12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME Samuel Wagner
13b. MOTHER'S MAIDEN NAME Jane Husk
14. NAME OF HUSBAND OR WIFE Grace F. Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 510-03-9914A
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Grace F. Wagner, Foster, Mo.

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Squamous Cell Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 8 mos

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Left Lung with massive
DUE TO (c) Hemorrhages — 1917

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/24/50 19___, *to* 6/7/50 19___, *that I last saw the deceased alive on* 6-7, 1950, *and that death occurred at* 9:50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE John H. Ogilvie (Degree or title) M.D.
23b. ADDRESS 130 Prof Bldg KCMO
23c. DATE SIGNED 6/9/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-10-50
24c. NAME OF CEMETERY OR CREMATORY Maple Hill
24d. LOCATION (City, town, or county) (State) K.C.K.

DATE REC'D BY LOCAL REG. 6-9-50
REGISTRAR'S SIGNATURE Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Simmons K.C.K.

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed H Simmons

Signed.....
Student Embalmer

Licensed Embalmer No. 3903

P. O. Address K C K

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.