

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5887

State File No.

FILED FEB 25 1952

BIRTH NO. _____ REG. DIST. NO. 287 PRIMARY REG. DIST. NO. 3048 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Mo. b. COUNTY Nodaway	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Conception	
c. LENGTH OF STAY (In this place) 1 mo.		d. STREET ADDRESS (If rural, give location) Conception Abbey	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Francis Hospital			

3. NAME OF DECEASED (Type or Print) Mr. Albert	a. (First)	b. (Middle)	c. (Last) Wagner	4. DATE OF DEATH (Month) Feb (Day) 18 (Year) 1952
---	------------	-------------	-------------------------	--

5. SEX male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Sept 5 1868	9. AGE (In years last birthday) 83	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Mins.
--------------------	-------------------------------	--	-------------------------------------	---	-----------------------	---------------------	----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) gen. laborer	10b. KIND OF BUSINESS OR INDUSTRY labor	11. BIRTHPLACE (State or foreign country) unknown	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	--	--	--

13a. FATHER'S NAME Edward Wagner	13b. MOTHER'S MAIDEN NAME Kerzella Jane Oberholzer	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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME, ADDRESS Father Walter Conception, Mo.
--	-------------------------------------	---

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHIOGENIC CARCINOMA		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 162X	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) (Min.)	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 Oct 15, 1951, to FEB 18, 1952, that I last saw the deceased alive on FEB 18, 1952, and that death occurred at 1:00 m., from the causes and on the date stated above.

23a. SIGNATURE Jane J. Kassel (Degree or title) M. D.	23b. ADDRESS Conception Jct., Mo.	23c. DATE SIGNED 2/19/52
---	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) 305-411	24b. DATE 2/20/52	24c. NAME OF CEMETERY OR CREMATORY Calamba	24d. LOCATION (City, town, or county) (State) Conception Nodaway Mo
--	--------------------------	---	--

DATE REC'D BY LOCAL REG. 2-23-52	REGISTRAR'S SIGNATURE Bernie Holt	25. FUNERAL DIRECTOR'S SIGNATURE Lester H. Shultz ADDRESS Shelby Mo
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Paul G. Keck

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 _____

Student Embalmer No. _____

~~working~~ under my personal supervision.

Student
Student Embalmer

Signed _____

Lester H. Phillips

Licensed Embalmer No. *1898*

P. O. Address _____

Starkbury, N

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.