

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7899**
Registrar's No. **230**

BIRTH NO. FILED **APR 15 1954** REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **5135**

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Ashhill		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Ashhill	
c. LENGTH OF STAY (In this place) 4 yrs		d. STREET ADDRESS (If rural, give location) 4 1/2 Mi, S.W. of Fisk	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4 1/2 Mi.S.W. of Fisk		e. STREET ADDRESS (If rural, give location) 4 1/2 Mi, S.W. of Fisk	

3. NAME OF DECEASED (Type or Print) a. (First) Connie b. (Middle) c. (Last) Wagster	4. DATE OF DEATH (Month) (Day) (Year) 3 30 54
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-26-1880	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 9	IF UNDER 1 YEAR Days 4	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Tenn	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Wagster	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lola Wagster
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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. -----	17. INFORMANT'S SIGNATURE OR NAME Lola Wagster, Fisk, Mo.	ADDRESS
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	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 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7:15	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22- I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Norman M. Phee (Degree or title)	23b. ADDRESS Coroner's Office, Butler, Mo.	23c. DATE SIGNED April 2-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-1-54	24c. NAME OF CEMETERY OR CREMATORY Brown Chapel	24d. LOCATION (City, town, or county) (State) Butler, Co., Mo.
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DATE REC'D BY LOCAL REG. 4/7/54	REGISTRAR'S SIGNATURE [Signature]	FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Fisk, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
APR 12 1951

BUTLER CO. HEALTH CENTER

FILE NO. _____

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, ~~by~~ 3-29

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Phil O. Lenczel

Licensed Embalmer No. 2936

P. O. Address Maple Bluff

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.