No. 300
10.48

2

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

FILED AUG 17 1954

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26453

BIRTH NO. --- REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 241

1. PLACE OF DEATH
a. COUNTY Calloway
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fulton
c. LENGTH OF STAY (in this place) 8 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital no. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY Phelps
c. CITY OR TOWN Rolla
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location) 0812

3. NAME OF DECEASED (Type or Print)
a. (First) James b. (Middle) — c. (Last) Wagoner

4. DATE OF DEATH (Month) (Day) (Year) Aug 6, 1954

5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 2
8. DATE OF BIRTH — 1885
9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Bell, Mo. 0
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Reuben Wagoner
13b. MOTHER'S MAIDEN NAME Tiny Dotson
14. NAME OF HUSBAND OR WIFE none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unknown
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred Wagoner, Rolla, Missouri

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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 002 X
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* Nov 22, 1946, *to* Aug 6, 1954, *that I last saw the deceased alive on* Aug 5, 1954, *and that death occurred at* 6:00 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) H. J. Fowler, M.D. by Severs
23b. ADDRESS State Hospital #1
23c. DATE SIGNED Aug 6 '54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 8/10/54
24c. NAME OF CEMETERY OR CREMATORY Kirksville Osteopathic College
24d. LOCATION (City, town, or county) (State) Kirksville Mo

DATE REC'D BY LOCAL REG. Aug. 14-1954
REGISTRAR'S SIGNATURE Maretta Lawrence
25. FUNERAL DIRECTOR'S SIGNATURE Maupin F. H.
ADDRESS Fulton Mo

(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 emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 37

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.