

FILED NOV 22 1954

STANDARD CERTIFICATE OF DEATH

39332

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9964**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Salem
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS unknown	812⁴ 8

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) VERDA	b. (Middle)	c. (Last) WAGONER	(Month) 10	(Day) 30	(Year) 54
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 2-28-1905	9. AGE (In years last birthday) 49	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) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Mena, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME James Swiger	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Fred Wagoner
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Hancock F.H., Salem, Ill.	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, asphyxia, 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) Encephalomalacia		(?)
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Generalized Arteriosclerosis and Raynaud's Disease 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	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4530
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22. I hereby certify that I attended the deceased from **4/26**, 1954, to **10/30**, 1954, that I last saw the deceased alive on **10/29**, 1954, and that death occurred at **9 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE Reekado, M.D.	(Degree or title) M.D.	23b. ADDRESS Hancock F.H., Salem, Ill.	23c. DATE SIGNED 11/1/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 10-30-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town or county) (State) Bristow OKLA.
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DATE REC'D BY LOCAL NOV 9 1954	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Hancock F.H., Salem, Ill.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *Ben Hoffman*.....

Licensed Embalmer No. *436*.....

P. O. Address *St Louis, Mo.*.....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**