

FILED MAY 4 1956

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

13541
State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1632</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (in this place) <u>54 YEARS</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>TRINITY LUTHERAN HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>74 5320 CHARLOTTE STREET 3740</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JESSE</u>		b. (Middle) <u>ALBERT</u>		c. (Last) <u>WAGNER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APR-11-1956</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JUNE 12; 1878</u> 9. AGE (In years) (last birthday) <u>77</u> 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) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COUNTRY CLUB DAIRY</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>NEAR BORDER MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>SAMUEL WAGNER</u>			13b. MOTHER'S MAIDEN NAME <u>MARY KELSO</u>		14. NAME OF HUSBAND OR WIFE <u>MRS. PEARL M. WAGNER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>496-24-2718</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MRS. PEARL M. WAGNER</u> ADDRESS <u>5320 CHARLOTTE ST. KANSAS CITY, MO.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prostatic Hypertrophy</u> 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 <u>unknown</u> <u>610X</u>	
19a. DATE OF OPERATION <u>10 Apr. 56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Prostatic Hypertrophy</u>				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)		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 <u>9 Apr</u> , 19 <u>56</u> , to <u>11 Apr</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 Apr</u> , 19 <u>56</u> , and that death occurred at <u>7:05 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>H. E. Carlson</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>1816 Professional Bldg</u>		23c. DATE SIGNED <u>11 Apr. 56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>APR-14-1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>4-14-56</u>		REGISTRAR'S SIGNATURE <u>neva marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D.H. Newcomer</u> ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>			

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

VS JUN 14 1950

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 *Robert Ray*.....

Licensed Embalmer No. *418*.....

P. O. Address *K.C. 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.