

Health,
Welfare
Public
Service

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

F. H. Wakefield

Director, Coroner, etc. must use only standard nomenclature in their reports. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13474
STATE FILE NUMBER

FILED MAY 7 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1932

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran		d. STREET ADDRESS 4111 So. Benton	
3. NAME OF DECEASED (Type or print) First LOUIS Middle HARRY Last WAGER JR.		4. DATE OF DEATH Month April Day 20 Year 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Vendor - mfg.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Louis Harry Wager Sr.		13b. MOTHER'S M maiden name Henrietta Sohl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give number) (If yes, give branch and dates of service) Yes		16. SOCIAL SECURITY NO. 495-03-6466	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) metastatic from Gall B. blocks		INTERVAL BETWEEN ONSET AND DEATH 155+	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Not related to the terminal disease condition given in PART I (a)) Obstruction Common Bile			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from Death occurred at 12:30 P.M. 20 April 1957		and last saw her alive on 20 April 1957	
22a. SIGNATURE (Degree or title) F. H. Wakefield M.D.		22b. ADDRESS 1102 Grand K. C. Mo	
22c. DATE SIGNED 4-27-1957			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE APR. 23 1957	23c. NAME OF CEMETERY OR CREMATORY Mt. Muncie Cem	23d. LOCATION (City, town, or county) (State) LEAVENWORTH, Kansas
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 4-23-57	26. REGISTRAR'S SIGNATURE neva minshall



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 *Everett L. Smith*

Licensed Embalmer No. *5001*

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.