

FILED MAY 19 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 491

300
1-57

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN SPRINGFIELD 0396 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1210 WILLOW LANE | | Length of stay in 1b 1 WEEK | d. STREET ADDRESS (If outside, give location) 1210 WILLOW LAND Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First NICHOLAS Middle P. Last WAGNER | | | 4. DATE OF DEATH Month MAY Day 9 Year 1958 | | |
|--|--|--|--|--|--|

| | | | | | | |
|-------------------------|----------------------------------|---|---|---|--|--|
| 5. SEX MALE 0 | 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 JULY 27 1891 | 9. AGE (In years as of birthday) 66 | 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) RETIRED | 10b. KIND OF BUSINESS OR INDUSTRY ARCHITECT | 11. BIRTHPLACE (City and state or country) NEWPORT, KENTUCKY | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|---|--|--|

| | | |
|--|---|---|
| 13a. FATHER'S NAME PETE WAGNER | 13b. MOTHER'S MAIDEN NAME UNKNOWN | 14. NAME OF HUSBAND OR WIFE DOLLIE WAGNER |
|--|---|---|

| | | |
|--|--|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give year or dates of service) YES W.W. # 1 | 16. SOCIAL SECURITY NO. 557-12-0188A | 17. INFORMANT Address MRS. DOLLIE WAGNER SPRINGFIELD, MO. |
|--|--|---|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Congestive heart failure</u> | |
| | DUE TO (c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | |
|---|--|
| 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 _____ a.m. _____ p.m. | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ |
|---|--|--|

| | | |
|---|--|--|
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ |
|---|--|--|

21. I attended the deceased from May 5, 1958 to May 9, 1958 and last saw ^{her} him alive on May 7, 1958
Death occurred at 9 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

| | | |
|---|--|------------------------------------|
| 22a. SIGNATURE (Degree or title) <i>Stueb. Schweitzer</i> M.D. | 22b. ADDRESS 410 Woodruff Building | 22c. DATE SIGNED 5-12-58 |
|---|--|------------------------------------|

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 5/14/58 | 23c. NAME OF CEMETERY OR CREMATORY WHITE CHAPEL | 23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO. |
|--|-----------------------------|---|--|

| | | | |
|--|------------------------------------|--|---|
| 24. FUNERAL DIRECTOR H.H. LOHMEYER | ADDRESS SPRINGFIELD, MO. | 25. DATE RECD. BY LOCAL REG. 5-12-58 | 26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i> |
|--|------------------------------------|--|---|

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{not} was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Crut

Signed *Gene Schmeyer*

Licensed Embalmer No. *4734*

P. O. Address *Spf, Ind*

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.