

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020190
STATE FILE NUMBER

360

3076

Registrar's No. 125

FILED JUN 12 1959

Registration District No.

Primary Registration District No.

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Harwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Nevada Hospital</u>			Length of stay in 1b		108 d. STREET ADDRESS <u>o</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>OSCAR WILLIAM WAGGONER</u>				First Middle Last		4. DATE OF DEATH Month Day Year <u>May 30 1959</u>			
5. SEX <u>M o</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 13, 1886</u>		9. AGE (In years (at birthday)) <u>72</u>	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming-Mortuary</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Jerico Springs, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>George W. Waggoner</u>			13b. MOTHER'S MAIDEN NAME <u>Bertha Jones</u>			14. NAME OF HUSBAND OR WIFE <u>Mabel Waggoner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>			16. SOCIAL SECURITY NO. <u>493-38-8317A</u>		17. INFORMANT Address <u>Martha Carrier Harwood, Missouri</u>				
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>Cerebral hemorrhage, left hemiplegia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertension</u>							<u>5 plus years</u>		
DUE TO (c) <u>Cerebral arteriosclerosis</u>							<u>unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus, (10 years) Chronic myocarditis.</u>							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 Month, Day, Year a.m. p.m.									
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 <u>June 8, 1951</u> to <u>May 30, 1959</u> and last saw him ^{her} alive on <u>May 30, 1959</u> Death occurred at <u>Nevada, Missouri</u> <u>3:45 a.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>L. D. McCall, M. D.</u>				22b. ADDRESS <u>Moore Building-Nevada, Mo.</u>				22c. DATE SIGNED <u>6/5/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 2, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harwood Cemetery</u>		23d. LOCATION (City, town, or country) <u>Harwood Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Ferry Funeral Home Nevada, Missouri</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>6-6-1959</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *L. Douglas Denny*

Licensed Embalmer No. *4960*

P. O. Address *Manada, Miss*

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.