

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036684

FILED VS SEP 21 1960

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8683

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. b. COUNTY Montgomery			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 day		c. CITY OR TOWN Litchfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION John Cochran Vets. Hosp			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 1010 West South Street			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HERBERT AUSTIN WAGNER				4. DATE OF DEATH Month Day Year Sept. 5, 1960			
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 7/6/20	9. AGE (last birthday) 40	IF UNDER 1 YEAR Months Days Hours Min. 1 29	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Sexton			10b. KIND OF BUSINESS OR INDUSTRY Elmwood Cemetery		11. BIRTHPLACE (City and state or country) Raymond, Illinois		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME William Wagner			13b. MOTHER'S MAIDEN NAME Lottie Harris		14. NAME OF HUSBAND OR WIFE Mrs. Herbert A. Wagner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W. W. II			16. SOCIAL SECURITY NO. Not Available	17. INFORMANT Address Lottie Wagner - Litchfield, Ill			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of the 3rd Cervical Vertebra, displaced.</i> DUE TO (b) <i>Tuberculosis of bones bilateral</i> DUE TO (c) <i>902.8-45</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Suffered in dive</i>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>into Big 4 Lake in Scraper City</i>					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <i>9 36 Illinois on or about Sept 3 1960</i>	20d. INJURY OCCURRED WHILE AT WORK <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.) <i>71 Lake</i>		20f. CITY, TOWN, OR LOCATION <i>Scraper City Ill</i>		
21. I attended the deceased from _____ to _____ and last saw her/him alive of _____ Death occurred at <i>5:05 P.</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Catrina Taylor Corner</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>9.6.60.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9/8/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Raymond Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Raymond, Illinois</i>			
24. FUNERAL DIRECTOR <i>D. Stouck</i> ADDRESS <i>E. St. Louis, Ill.</i>			25. DATE RECD. BY LOCAL REG. <i>SEP 8 1960</i>	26. REGISTRAR'S SIGNATURE <i>Neal Smith, M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Not Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed [Signature]

Licensed Embalmer No. Ill. 75

P. O. Address 611. 10011

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to conform 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.