

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4528 61-033172
STATE FILE NUMBER

AMENDED

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

FILED SEP 25 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Jackson		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		a. STATE Mo		b. COUNTY Jackson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Lukes		Length of stay in 1b 55 Yrs		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 3818 Highland		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First CECIL		Middle J		Last WAGNER		Month Day Year 9 8 1961	
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 9-23-1898	9. AGE (last Birthday) 62 Yrs	IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Handler		10b. KIND OF BUSINESS OR INDUSTRY K. C. Terminal R. R. St. Joseph, Missouri		11. BIRTHPLACE (City and state or country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John Wagner			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Frances Wagner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Frances Wagner 3818 Highland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardio-respiratory failure with coma						9 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bullous emphysema - bilateral						20 years	
DUE TO (c) Coronary atherosclerosis						5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 checked="" type="checkbox"/> NO <input 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. Month, Day, Year		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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 2-13-58 to 9-8-61 and last saw her him alive on 9-8-61 Death occurred at 5:05 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) James P. Chambers Jr. M.D.				22b. ADDRESS 412 Plaza Parkway Bldg., Kansas City 12, Mo.		22c. DATE SIGNED 9-11-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-12-61		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR ADDRESS Stine & McClure Kansas City, Mo				25. DATE RECD. BY LOCAL REG. 9-11-61		26. REGISTRAR'S SIGNATURE Keith Long	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

James P. Chambers, Jr. Medical Certification

Miss A.M.

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 Thomas A. Schler

Licensed Embalmer No. 4995

P. O. Address KC, 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.