

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-040597**

STATE FILE NUMBER

Registration District No. 195 Primary Registration District No. 4309 Registrar's No. 59-63

**FILED NOV 14 1963**

DO NOT WRITE ON THIS STUB  
AMENDED

1. PLACE OF DEATH a. COUNTY <u>MCDONALD</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>MCDONALD</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>SOUTHWEST CITY</u>		Length of stay in lb <u>1 1/2 yrs.</u>	c. CITY OR TOWN <u>SOUTHWEST CITY</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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>HAROLD GOUDY WAGNER</u>			4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1963</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/6/1882</u>	9. AGE (last birthday) <u>81</u>	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) <u>EXECUTIVE RAILROAD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROADING</u>		11. BIRTHPLACE (City and state or country) <u>SEYMOUR, IOWA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>BENJAMIN F. WAGNER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY E. GOUDY</u>		14. NAME OF HUSBAND OR WIFE <u>MYRTLE WAGNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of serv) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MYRTLE WAGNER</u> Address <u>SOUTHWEST CITY, MO.</u>		

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) <u>CORONARY OCCLUSION</u>		
DUE TO (b) <u>CORONARY ARTERY DISEASE</u>		
DUE TO (c) <u>ARTERIOSCLEROSIS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>SENILITY</u>		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 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 1959 to Nov. 6, 1963 and last saw him alive on 11-5-1963  
Death occurred at 5:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>Tenerville, Mo.</u>	22c. DATE SIGNED <u>11-8-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11/8/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILLS</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO.</u>
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24. FUNERAL DIRECTOR <u>DOWNEY-WOODARD-MORNEY-NOEL, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 7, 1963</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300  
Rev. 4/59

10600

20600

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12 90-11

13 10

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT BY AFFIDAVIT OF

MEDICAL CERTIFICATION

NOV 27 1963

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 Douglas G. Mamey

Licensed Embalmer No. 5199

P. O. Address Anderson, 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.

Removal Permit issued 11-7-63