

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

11256

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **003**

City **Spring** No. **City Hospital**

File No.

Registered No. **3090**

St. Ward

2. FULL NAME **Thomas Wagoner**

(a) Residence. No. **4435a Bluff** St. **18** Ward.

Length of residence in city or town where death occurred **6** yrs. mos. da.

How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Ethel Wagoner

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

June 22 1906

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, ____ hrs. or ____ min.

31

8

25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Student

(b) General nature of industry, business, or establishment in which employed (or employer)

as above

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

PARENTS

10. NAME OF FATHER

Geo Wagoner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

12. MAIDEN NAME OF MOTHER

Ethel Woods

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14.

INFORMANT (Address)

**City Hospital
Spring
City Hospital**

15.

FILED

APR 19 1928

Mar C Staley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

March 18 1928

17.

I HEREBY CERTIFY, That I attended deceased from **Feb 14 1928**, to **March 18 1928** that I last saw him alive on **March 18 1928**, and that death occurred, on the date stated above, at **8** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Pulmonary Tuberculosis

23A

(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **Henry C. Westerman** M.D.
3/19 1928 (Address) **City Hospital**

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Salem Mo

3-20-1928

20. UNDERTAKER

ADDRESS

The Amburster Mord Co
34 Mendocino

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

G. H. Godwin
Wagoner