

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

Do not use this space.

23976

File No. _____
Registered No. **375** St. _____ Ward _____

PLACE OF DEATH

County Randolph Registration District No. 735
Township _____ Primary Registration District No. 3034
City Moberly (No. 722 W. Coates)

FULL NAME O. Telia W. Wagner

(a) Residence. No. 722 W. Coates St. _____ Ward _____

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 8th 1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 5 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER W^m Huppincott
11. BIRTHPLACE OF FATHER (CITY OR TOWN) NJ
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Frances Colewell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Pa
(STATE OR COUNTRY)

14. INFORMANT W. S. Wagner
(Address) Moberly, Mo

15. FILED 1/29 1930 Dr. J. H. Stelling
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27th 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1930, to July 27th 1930, that I last saw her alive on July 27th 1930, and that death occurred, on the date stated above, at W. P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility
870
162 (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Paralysis agitans
(SECONDARY) (duration) 4 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) C. R. Herkness M. D.

7-29th 1930 (Address) Moberly Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Moberly Mo DATE OF BURIAL 7-29th 1930

20. UNDERTAKER Mahan & Son ADDRESS Moberly Mo

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.

AUG 26 1930

