

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.

JAN 16 1939 RECD FEB 7 1939

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

3764  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 284  
 (b) Township Clayton Primary Registration District No. 101  
 (c) City Clayton (d) Street No. St. Louis County Hospital Registered No. 92  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wagner, Baby Boy

(a) Residence, No. 164 Military Rd. Luxemburg, Mo. (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1/15/39

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
Stillbirth

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Clayton (STATE OR COUNTRY) Mo.

FATHER 13. NAME Andrew Wagner

14. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Frances Buskehl

16. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo

17. INFORMANT father, Andrew Wagner (ADDRESS) 164 Military Rd. Luxemburg.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mattew, Mo DATE Jan 17/39

19. FUNERAL DIRECTOR (NAME) Funder's and Co (ADDRESS) 7420 Michigan

20. FILED JAN 16 1939 Local Registrar. L. M. Cronberg (Address) Co. Mo.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/15/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 1/15/39, 19, to 1/15/39, 19.

I last saw him alive on stillbirth, 19. Death is said to have occurred on the date stated above, at 11:20A.M.

The principal cause of death and related causes of importance were as follows:

Injury at birth  
(Without Caesarian - Cerebral Hemorrhage)

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) L. M. Cronberg, M. D.

(Address) Co. Mo.

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**