

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.

W 87 Miss AUG 7 1939 Hospital

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

24598
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Raw Primary Registration District No. 1007 Registered No. 2811
 (c) City St. Marys Hospital (d) Street No. St. Marys Hospital St.
 (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

(a) Residence, No. Roscoe M. Waggnor (Roscoe M. Waggnor) St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (single)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 11 1919

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 7 24

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

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

FATHER 13. NAME Geo. Waggnor

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk Mo

MOTHER 15. MAIDEN NAME May Johnston

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

17. INFORMANT (ADDRESS) Geo. Waggnor Urbana Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Bowers Co DATE July 9 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Pat Luckey whatland Mo

20. FILED July 12 1939 M. M. Crome Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7 1939

22. I HEREBY CERTIFY, That attended deceased from Nov 18 1938 to July 7 1939

I last saw him alive on July 7 1939 Death is said to have occurred on the date stated above, at 12:35 p.m.

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

actinomycosis systemic
012-202

Date of onset

Other contributory causes of importance:

none

Name of operation none Date of

What test confirmed diagnosis? Microscopic there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

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) Paul Stogee M. D.

(Address) 820 Argyle St

Urbana Mo

D. H. H. H. H.

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, W. O.

J. P. Luckey, or by _____

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

Signed J. P. Luckey
Licensed Embalmer No. 2982

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.