

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24113**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **2723**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3200 Norledge about 1 Month.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community **74 Years.**

3. (a) PRINT FULL NAME **Louis Wager** **260**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Feb. 2nd, 1866**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	74	5	3	hr. _____ min.

9. Birthplace **Leavenworth, Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cabinet Maker**

11. Industry or business _____

12. Name **Sevastian Wager**
Germany

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name **Agnes Griswold**

15. Birthplace **France**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Garria Myers**

(b) Address **2830 Wabash, K.C. Mo.**

17. (a) **Burial** (b) Date thereof **July 8th, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. St. Mary's**

18. (a) Signature of funeral director **Mrs. C. L. Forster**

(b) Address **918 Brooklyn Avenue, K.C. Mo.**

19. (a) **July 7, 1940** (b) **M. M. Craue**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1648 Penn. Avenue, K.C. Mo.**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **5th**, year **1940** hour _____ minute **A.M.**

21. I hereby certify that I attended the deceased from **Feb - 1940**, 19 _____, to **July 5**, 19 **40**; that I last saw him alive on **June 25**, 19 **40**, and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to **Hypertension** 1/31

Due to **Cerebral vessel - occlusion disease**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____

Duration ?
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **361**
(Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature **Lo H W y c d** (M. D. number) _____
 Address **3850 Prospect** Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

39th, and respect
427

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

Wm. C. Browning

Licensed Embalmer No. *2724*

P. O. Address *W. C. No*

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.