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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED NOV 20 1946**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37223**  
Registrar's No. **4648**

Registration District No. **149** Primary Registration District No. **1002**

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

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hosp. A  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Infant Wagner

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female 5. Color of 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 Nov. 3, 1946  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
		<u>1</u>	<u>8 40 min</u>

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

10. Usual occupation Child

11. Industry or business

**MOTHER FATHER**

12. Name Theodore F. Wagner

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

14. Maiden name Beatrice O'Brien

15. Birthplace Parsons, Kas.  
(City, town, or county) (State or foreign country)

16. (a) Informant Theodore F. Wagner

(b) Address 7128 Baltimore Ave.

17. (a) Burial (b) Date thereof Nov. 5, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director: Thos. E. Quirk Funeral Home

(b) Address 4316 Troost Ave.

19. (a) 11-5-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 7128 Baltimore Ave.  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov. day 4th.  
year 1946 hour 12.10 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Nov. 3  
that I last saw him alive on Nov. 4, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Obstruction of Spleen Duration 1 day

Due to pernativity - 6 months pregnancy with mother

Other conditions ---  
(Include pregnancy within 3 months of death)

Major findings: --- **159**

Of operations ---

Of autopsy ---

**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? Home

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature John T. Schuman (M. D. or other) MD

Address 116 28th Ave Date signed 11-5-46

**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 Thomas E. Ziv  
Licensed Embalmer No. 3775  
P. O. Address A. O. Md

**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, fact should be so stated above.**