No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11651

FILED APR 8 1947 #65320

Registration District No. 318 Primary Registration District No. 1002 Registrar's No. 3282

1. PLACE OF DEATH:

(a) County

(b) City or town St.Louis,Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St.Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St.Louis 17
(If outside city or town limits, write "RURAL") 25

(d) Street No. 823 N. 6th St., Memorial 9
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME WILLIAM WAGNER

3. (b) If veteran, name war --- 3. (c) Social Security No. ---

4. Sex male 0 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 February 9th,? (Month) (Day) (Year)

8. AGE: Years abt-50? Months Days If less than one day hr. min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation Waiter

11. Industry or business

FATHER
12. Name George Wagner
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Oma Triplen
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant M.Renard
(b) Address St.Louis City Hospital.

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 3-6-47 (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W Richter
(b) Address 3500 Rutgers St.

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 26th
year 1947 hour 10:40 minute A M.

21. I hereby certify that I attended the deceased from 2/23/47, 19, to 2/26/47, 19;
that I last saw him alive on 2/26/47, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Bronchial asthma

Due to

Due to 112

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature 1515 Lafayette 2/27/47 (Date of other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.