

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34729

34729

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 925-A

0396
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY CHRISTIAN	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD	c. LENGTH OF STAY (in this place) 5 DAYS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN "RURAL" POLK 0220	
d. FULL NAME OF HOSPITAL OR INSTITUTION BURGE HOSPITAL		d. STREET ADDRESS (If rural, give location) RT. # 2, BILLINGS.	

3. NAME OF DECEASED (Type or Print)	a. (First) CHRISTIAN	b. (Middle) OTTO	c. (Last) WAGEMANN	4. DATE OF DEATH (Month) (Day) (Year) OCT. 12-1952
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 1	8. DATE OF BIRTH OCT. 14-1888	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) BILLINGS - MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME WILLIAM WAGEMANN	13b. MOTHER'S MAIDEN NAME LOUISE ENGLE BRECHT	14. NAME OF HUSBAND OR WIFE MARGARET SCHAUMANN WAGEMANN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADOLPH WAGEMANN, BILLINGS, MO.	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4500	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan**, 1952, to **Oct**, 1952, that I last saw the deceased alive on **11 Oct**, 1952, and that death occurred at **3:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Karl Leidinger Jr MD (Degree or title)	23b. ADDRESS Republic, MO	23c. DATE SIGNED 10-16-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE OCT. 14-1952	24c. NAME OF CEMETERY OR CREMATORY ST. PETER'S EVANGELICAL	24d. LOCATION (City, town, or county) (State) BILLINGS MISSOURI
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DATE REC'D BY LOCAL REG. 10-20-52	REGISTRAR'S SIGNATURE Edith Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE John Dean Harris ADDRESS Clevers, 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.....

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working under my personal supervision.

Student Embalmer No.....

Signed.....

John Alan Harris

Signed.....
Student Embalmer

Licensed Embalmer No. 4390

P. O. Address Cleveland, Mo.

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.