

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4245**  
Registrar's No. **150**

FILED MAR 8 1954  
BIRTH NO. REG. DIST. NO. **55** PRIMARY REG. DIST. NO. **3011**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Carrollton</b>	c. LENGTH OF STAY (In this place) <b>1 1/2 years</b>	c. CITY OR TOWN <b>Bosworth</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>403 West Heidle.</b>		e. STREET ADDRESS (If rural, give location) <b>RFD-6 n/w Bosworth.</b> <b>0170</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>ROBERT</b>	b. (Middle) <b>C</b>	c. (Last) <b>WAGNER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 23, 1954</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed.</b>	8. DATE OF BIRTH <b>Jan. 25, 1871</b>
9. AGE (In years) last birthday <b>83</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>28</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Cedar County Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Jacob Wagner,</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine Lippincott</b>	14. NAME OF HUSBAND OR WIFE <b>Martha Jane (Causey) Wagner.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Sylvia Dungan, Bosworth, Mo.</b>

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <b>Myocardial</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Collapse due to</b> DUE TO (c) <b>Impairment of old age</b>		
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 <b>4222</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)	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 **Feb 23, 1954** to **Feb 23, 1954**, that I last saw the deceased alive on **Feb 23, 1954**, and that death occurred at **11:00 P.M.** from the causes and on the date stated above.

23a. SIGNATURE (Signature or title) <b>R. H. Smith, M.D.</b>	23b. ADDRESS <b>Carrollton, Mo.</b>	23c. DATE SIGNED <b>2/24/54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>2/25/1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Big Creek cemetery</b>
24d. LOCATION (City, town, or county) (State) <b>Bosworth, Missouri</b>		

DATE REC'D BY LOCAL REG. <b>2/28/54</b>	REGISTRAR'S SIGNATURE <b>Mr. Herbert Calverto</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Clifford W. Austin, Tina, Mo.</b>
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

**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 ..... Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Ben G. Gibson* .....

Licensed Embalmer No. *2961* .....

P. O. Address *Carrollton* .....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**