

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24022**
3117

FILED AUG 8 - 1956

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|--|--|--|--|---|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. _____ | |
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) -a.-STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> | | | |
| b. CITY OR TOWN <u>KANSAS CITY</u> | | c. LENGTH OF STAY (in this place) <u>18 YEARS</u> | | c. CITY OR TOWN <u>KANSAS CITY</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3250 MICHIGAN AVENUE</u> | | | | STREET ADDRESS (If rural, give location) <u>3250 MICHIGAN AVENUE</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>JAMES WILLIAM WAGNER</u> | | a. (First) <u>JAMES</u> | | b. (Middle) <u>WILLIAM</u> | | c. (Last) <u>WAGNER</u> | |
| 4. DATE OF DEATH <u>JULY 16 1956</u> | | (Month) <u>JULY</u> | | (Day) <u>16</u> | | (Year) <u>1956</u> | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>APR. 3 1889</u> | |
| 9. AGE (In years last birthday) <u>67</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 1 HR. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>FORT SCOTT, KANSAS</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>JAMES FRANKLIN WAGNER</u> | | 13b. MOTHER'S MAIDEN NAME <u>SARAH ANNE TYLER</u> | | 14. NAME OF HUSBAND OR WIFE <u>MRS. EVELYN WAGNER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>496-10-8351</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>MRS. EVELYN WAGNER</u> ADDRESS <u>3250 MICHIGAN KANSAS CITY, MO.</u> | | | |
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chl. valvulordis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Asthma, chl. bronchitis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>4214</u> <u>years</u> | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | 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 <u>1950</u> , 19____, to <u>7/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/15</u> , 19 <u>56</u> , and that death occurred at <u>10:05 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>H. C. Trippe</u> (Degree or title) <u>MD</u> | | | | 23b. ADDRESS <u>6247 Brookside</u> | | 23c. DATE SIGNED <u>7/16/56</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>JULY 18 1956</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u> | | 24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u> | |
| DATE REC'D BY LOCAL REG. <u>7-18-56</u> | | REGISTRAR'S SIGNATURE <u>Deva Marshall</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Newcomer</u> ADDRESS <u>1391 BRUSH CREEK KANSAS CITY, MO.</u> | | | |

WRITE PLAINLY—USING UNFADING 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 *Chester K. Brown*

Licensed Embalmer No. *4931*

P. O. Address *K E Va*

**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.**