

Dr. Fitch

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021036

STATE FILE NUMBER

FILED JUN 30 1959

Registration District No. 128 Primary Registration District No. 2002 Registrar's No. 681

100
57

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Length of stay in 1b 27 YRS.	d. STREET ADDRESS (If outside, give location) 937 N. CAMPBELL Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last NORA AGNES WAGEN			4. DATE OF DEATH Month Day Year JUNE 22 1959
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 5 1889
9. AGE (In years birth day)		FUNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MANKATO, MINN.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME CORNELIUS FITZGERALD	
13b. MOTHER'S MAIDEN NAME ELLEN GALLAGHER		14. NAME OF HUSBAND OR WIFE FRANK WAGEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 491-05-0111	17. INFORMANT Address FRANK WAGEN SPRINGFIELD, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Renal-Vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>NK</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>442X</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>8-8-49</u> , to <u>6-22-59</u> and last saw her alive on <u>6-21-59</u> Death occurred at <u>4:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. Fitch</u> (Deputy Registrar)		22b. ADDRESS <u>1715 BOONVILLE SPRINGFIELD MO</u>	22c. DATE SIGNED <u>6-23-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 6/24/59	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.
24. FUNERAL DIRECTOR H. H. LOHMEYER		ADDRESS SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 6-24-59
26. REGISTRAR'S SIGNATURE <u>Effie B. Melton</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DEC 29 1959

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 *H. M. C. Carr*

Licensed Embalmer No. *2727*

P. O. Address *Appl. 1218*

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.