

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-029965

STATE FILE NUMBER

Registration District No. 172 Primary Registration District No. 4270-4272 Registrar's No. 60

AMENDED

FILED AUG 16 1961

1. PLACE OF DEATH a. COUNTY <u>WAGGATER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>SALINE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WAVERLY</u>		Length of stay in 1b <u>25 DAYS</u>	c. CITY OR TOWN <u>BLACKBURN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Kelling Clark & Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Blackburn</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL FRANKLIN WAGNER</u>			4. DATE OF DEATH Month Day Year <u>Aug. 8 1961</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16 1878</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>22</u> Hours <u></u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>POST MASTER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Warren Co. Mo</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Charles E. Wagner</u>	13b. MOTHER'S MAIDEN NAME <u>MARY MEYER</u>	14. NAME OF HUSBAND OR WIFE <u>Willie Maddox</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>None</u>	17. INFORMANT <u>Charles William Wagner</u> Address

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 Vascular Renal Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____		

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
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21. I attended the deceased from 1946, to Aug-8-61 and last saw him alive on Aug-8-61
Death occurred at 10:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Douglas Kelling M.D.</u>	22b. ADDRESS <u>Waverly Mo</u>	22c. DATE SIGNED <u>8/9/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 10</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blackburn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Blackburn Mo</u>
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24. FUNERAL DIRECTOR <u>Gene Miller, Blackburn Mo</u>	ADDRESS <u>Blackburn Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Aug-9-1961</u>	26. REGISTRAR'S SIGNATURE <u>Lutie Gordon Jordan</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

DATE AMENDED

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 Wesley Miller

Licensed Embalmer No. 4785

P. O. Address South Springs

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.