PLACE OF DEATH

County Stone

Township Washington
or
Village
or
City (NO. , St.; Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 843 File No. 43642-2

Primary Registration District No. 6106 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William H.Rogers

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH April 1838 (Month) (Day) 1 (Year)

AGE 79 yrs. 8 mos. X XX ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Athens Ill.

PARENTS
NAME OF FATHER Henry C.Rogers
BIRTHPLACE OF FATHER (City or town, State or foreign country) Penn.
MAIDEN NAME OF MOTHER Sarah Moore
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R.B.Rogers

(ADDRESS) Galena Mo.

Filed Jan 20th 1918 L. Henson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2 Dec. 30th. 1917. (Month) (Day) 191 (Year)

I HEREBY CERTIFY, that I attended deceased from about Dec. 20th, 1917 to , 191 , that I last saw him alive on Dec. 20th. 1917, 191 , and that death occurred, on the date stated above, at 10.40 P.M.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

82H
77

64

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Cerebral Hemorrhage

8 (Duration) ✓ yrs. ✓ mos. 6 ds.

(Signed) Jan 20-1918 L. Henson M. D.

Feb 20, 1917 (Address) Galena Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Galena Cemetery

DATE OF BURIAL ✓ , 191

UNDERTAKER

ADDRESS Galena Mo.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO.....,.....St.;.....Ward)

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month) .....(Day), *1*.....(Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed .....,191....,.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....(Month) .....(Day), *191*.....(Year)

I HEREBY CERTIFY, that I attended deceased from .....,191....., to.....,191....., that I last saw h.....alive on.....,191....., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

.....,191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	.....,191....
UNDERTAKER	ADDRESS

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

1 PLACE OF DEATH

County Stone

Township Washington
or
Village
or
City (NO. St.; Ward)

Registration District No. 843 File No.

Primary Registration District No. 6106 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William H. Rogers

SUPPLEMENTARY

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) M

6 DATE OF BIRTH (Month) (Day) 1 (Year)

7 AGE yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed, 191, L. Henson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 30, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from, 191, to, 191, that I last saw h alive on, 191, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

, 191 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Galena Cemetery

DATE OF BURIAL Jan. 2, 1918

20 UNDERTAKER Craig Merc. Co.

ADDRESS Galena Mo.

Original file, date Jan. 20, 1918

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples; (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

43642-2