

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

Do not use this space.

1. PLACE OF DEATH

County Cass
Township Shell Knob T.O.
City Shell Knob Mo (Name)

Registration District No. 29
Primary Registration District No. 5059

File No. 7175-2
Registered No. 47
St. _____ (Word)

2. FULL NAME Franklin M. Rogers

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word). married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Linda L Rogers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
81 Unknown

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) ✓

14. INFORMANT Linda L Rogers
(Address) Shell Knob Mo

15. FILED Nov 11 19 27 Mrs N. R. Williams
REGISTRAR Dpt.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 12 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1927, to Mar 7, 1927, that I last saw h. live alive on Mar 7, 1927, and that death occurred, on the date stated above, at 3.65 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

CONTRIBUTORY (SECONDARY) IB

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH. NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS. Symptomatic
(Signed) Elmer W. Dwyer, M. D.

1164 1/2 1927 (Address) Cassville Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Mckenaw Cemetery 3/12 1927

20. UNDERTAKER ADDRESS
Horner Funeral Service Cassville Mo.

N. B.—Every item of information should be carefully supplied. A C. name to be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Barry
Township Shell Knob
City..... (No.....)..... St. Ward)

Registration District No. 38
Primary Registration District No. 5051

File No. 7
Registered No. 47

2. FULL NAME

Franklin M. Rogers

(a) Residence. No..... St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration)..... yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY).....

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

14. INFORMANT (Address).....

15. FILED 7 1927 Emma Wedding REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 12 1927

17. I HEREBY CERTIFY That I attended deceased from....., 19....., 19..... that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19..... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

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

A. B. PART of information could be careful. apply. AU. should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-1175A