JUL 27 1927

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

Do not use this space.

21788

1. PLACE OF DEATH
County Johnson. Registration District No. 431
Township Warrensburg. Primary Registration District No. 3023
City Warrensburg. (No. ..... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME Mrs. Eliza Rogers.
(a) Residence. No. 400, E. Market St. St., 2nd 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mr. J. D. Rogers.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April. 8, 1840.

7. AGE: 87 YEARS; MONTHS: 2; DAYS: 28; If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) Randolph Co.
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Bartholemew Heifner.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) K y.
12. MAIDEN NAME OF MOTHER Mary Hockersmith.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky.

14. INFORMANT Miss Florence Rogers.
(Address) Warrensburg. Mo.

15. FILED July 7, 1927 Wm R Patterson REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July. 6, 1927.

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1926, to July 6, 1927 that I last saw h. ... alive on July 6, 1927 and that death occurred, on the date stated above, at 2; P. M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1 Uremia
1 ...
1 ...
1 ... (duration) ..... yrs. 1 mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) John A Powers M.D
19 (Address) Warrensburg 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: Sun Set Hill Cemetery
DATE OF BURIAL: July. 7, 1927

20. UNDERTAKER: R. Q. Phillips.
ADDRESS: Warrensburg. MO.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied.

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: Johnson — Registration District No.: 431 — File No.:
Township: — Primary Registration District No.: 3023 — Registered No.:
City: Warrensburg — St. — Ward)

2. FULL NAME: Mrs. Eliza Rogers
(a) Residence. No. — St. — Ward. (If nonresident give city or town and State)
(Usual place of abode)
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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Wd.

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

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTY)

14. INFORMANT
(Address)

15. FILED ..... 19 ..... W. Nallessoll
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 6 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Urinary Carcinomatous
Nephritis
(duration) 1 yrs. 1 mos. ds.
CONTRIBUTORY (SECONDARY) Senile City
(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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

1279B

N. B.—Every item of information should be carefully and fully answered. AGE should be stated in YEARS, MONTHS and DAYS. PHYSICIANS should state very usual or informal name of disease, so that it may be properly classified. Exact statement of OCCUPATION is very important. USE OF DEATH in place of [illegible], so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD

THEY ARE COMPLETE AS PRESCRIBED BY LAW

I NOT RECEIVE A FEE FOR CERTIFICATES UNTI

S-21788