

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

Do not use this space.

35622

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. 791  
Primary Registration District No. 1003

File No. ....  
Registered No. 11338  
St. .... (Ward)

**2. FULL NAME**

(a) Residence. No. 214 S. 27th St., 22 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male | 4. COLOR OR RACE Col. | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) \_\_\_\_\_

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 13, 1927

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, 2 hrs. or 2 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 COUNTRY) St. Louis, Mo.

10. NAME OF FATHER David Rogers

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

12. MAIDEN NAME OF MOTHER Powers Blair

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

14. INFORMANT (Address) Anna J. Woodard City Hospital #2

15. FILED DEC 19 1927 Maule Starkeoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 13, 1927

17. I HEREBY CERTIFY That I attended deceased from 11/13, 1927 to 11/13, 1927 that I last saw him alive on 11/13, 1927, and that death occurred, on the date stated above, at 7:00 A.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pneumonia  
15 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 16/10 (duration) yrs. mos. da.

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 clinical  
(Signed) Doc Howell, M. D.  
, 19 (Address) City Hosp #2

\*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 POTTERS FIELD. DATE OF BURIAL 11-22-1927

20. UNDERTAKER P. Weston 2945 Lawton ADDRESS

N. B.—Every item of information should be carefully supplied. AGE 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.

DEPARTMENT RECORD

