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

Do not use this space.
27698
3387

399

1. PLACE OF DEATH

County Jackson — Registration District No. ____ — File No. ____

Township Kaw — Primary Registration District No. 1002 — Registered No. ____

City Kansas City (No. K.C. General Hospital St. ____ Ward)

2. FULL NAME Rogers Jack

(a) Residence. No. 547 Main St., / Ward. ____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 7 1889

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
	40	1	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(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) Georgia

PARENTS

10. NAME OF FATHER R. E. Rogers

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

12. MAIDEN NAME OF MOTHER Mary Smith

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

14. INFORMANT Ward Clerk
(Address) K.C. General Hosp.

15. FILED 8/7, 1929 M. M. Crowe asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-4 1929

17. I HEREBY CERTIFY, That I attended deceased from 7-22, 1929 to 8-4, 1929 that I last saw h. alive on 8-4, 1929 and that death occurred, on the date stated above, at 6:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Multiple strictures of urethra
136A (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) Pelvic Peritonitis
129 (duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED ____
IF NOT AT PLACE OF DEATH ____
DID AN OPERATION PRECEDE DEATH? yes DATE OF 7-26-29
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? ____

(Signed) T. H. Wakefield, M. D.
8-5, 1929 (Address) Night Supt. K.C. General Hosp.

*State the DISEASE CAUSING DEATH, or if due thereto 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
Atlanta Georgia	8-7 1929
20. UNDERTAKER	**ADDRESS**
O V Mast	1915 E 15

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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