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

Do not use this space.

3799

1. PLACE OF DEATH
County Texas
Township Current
City Unice (No. ..... St. ..... Ward)

Registration District No. 866
Primary Registration District No. 6146

File No. 95
Registered No. 95

2. FULL NAME Dr Franklin 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11 July 1845

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	84	5	4	

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

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

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dunlap
(STATE OR COUNTRY) Tenn
12. MAIDEN NAME OF MOTHER Gracen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tennessee

14. INFORMANT John Rogers
(Address) Unice Mo.

15. FILED 1-11, 1930 Mrs W. R. McKee
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-6 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct-1-, 1929, to 1-6-, 1930, that I last saw him alive on 1-4-, 1930, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epithelioma of Lower Lip
Caused from pipe stem
45A
..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 43
..... (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) L H Walker, M. D.
1-11, 1930 (Address) Summerville 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 Spring Valley cem. Wednesday Jan 8
DATE OF BURIAL 1-8 1930

20. UNDERTAKER G W Ellwitt
ADDRESS Cabool

CAUSE OF DEATH in plain terms, so that it may be properly cla...