LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

MAY 27 1936

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

298 16643

V. S. No. 2.

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.

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

MARGIN RESERVED FOR BINDING

PLACE OF DEATH.

County: St Francois — Registration District No.: 772 — File No.:

Township: St Francois — Primary Registration District No.: 4463 — Registered No.:

City: Elvins (No. ..., ... St. ..... Ward)

FULL NAME: James Lester Rodgers

(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

SEX: M — 4. COLOR OR RACE: White — 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Child

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Child

DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 2nd 1936

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	2	29	

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

BIRTHPLACE (CITY OR TOWN): Elvins
(STATE OR COUNTRY): Mo

10. NAME OF FATHER: Lenord Rodgers

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

12. MAIDEN NAME OF MOTHER: Pearl Lohstroman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Doe Run
(STATE OR COUNTRY): Mo

INFORMANT: Lenord Rodgers
(Address): Elvins Mo

FILED: 4/27, 1936 — C B Farrar, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 1 1936

17. I HEREBY CERTIFY, That I attended deceased from Mar 26, 1936, to April 1, 1936, that I last saw h. alive on April 1, 1936, and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lung abscess Chronic
10 Ds
(duration) ... yrs. ... mos. ... ds.

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

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? Sputum X-ray
(Signed) C B Farrar, M. D.
, 19 (Address) Flat River 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Wood Lawn Cemetery — DATE OF BURIAL: 4-2 1936

20. UNDERTAKER: Caldwell Bros — ADDRESS: Flat River

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No. ....., ... St. ..... Ward

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	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)

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 COUNTRY)

PARENTS

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 .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

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).....

, 19 (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIA
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

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.