

FEB 21 1939

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

2585
Do not use this space.

1. PLACE OF DEATH
 (a) County **Jackson** Registration District No. **396**
 (b) Township **Ft Osage** Primary Registration District No. **552** Registered No. _____
 (c) City **Near Buckner-Mo.** (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred **70** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
267 **BARTON WARREN ROGERS**
2. PRINT FULL NAME
Buckner Mo. RR. No. 1.
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Dec. 28 1840**

7. AGE YEARS **89** MONTHS **0** DAYS **20** If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **farmer**
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) **Franklin County** (STATE OR COUNTRY) **Missouri**

FATHER
 13. NAME **William S. Rogers**
 14. BIRTHPLACE (CITY OR TOWN) **Calloway County** (STATE OR COUNTRY) **Missouri**

MOTHER
 15. MAIDEN NAME **Emily Miller**
 16. BIRTHPLACE (CITY OR TOWN) **Franklin County** (STATE OR COUNTRY) **Missouri**

17. INFORMANT **Mrs. D. J. VanDyke** (ADDRESS) **Buckner Mo. RR. No. 1.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Six Mile Cem.** DATE **Jan. 21. 1939**

19. FUNERAL DIRECTOR (NAME) **V. M. Reupert.** (ADDRESS) **Buckner Mo. No. 2321.**

20. FILED **Jan 19, 1939** **John W. Robinson** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 18 1939**

22. I HEREBY CERTIFY, that I attended deceased from **Dec 13, 1938** to **Jan 18, 1939**
 I last saw him alive on **Jan 16, 1939** Death is said to have occurred on the date stated above, at **1:30 P.M.**
 The principal cause of death and related causes of importance were as follows:
Hypostatic Pneumonia
 Date of onset _____

Other contributory causes of importance:
89 yrs.

Name of operation **None** Date of _____
 What test confirmed diagnosis? **Chemical** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19____
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **no**
 If so, specify _____
 (Signed) **John W. Robinson**, M. D.
 (Address) **Buckner, MO.**

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.

1119

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

V.M. Reppert.

or by

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No. **2321**

P. O. Address **Buckner MO.**

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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2585
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1. PLACE OF DEATH

(a) County Jackson Registration District No. 396
(b) Township St. George Primary Registration District No. 0352 Registered No. _____
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Barton Warren Rogers
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED s
(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.
89 0 20

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED June 6 1939 John W. Robertson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-18-1939

22. I HEREBY CERTIFY, That I attended deceased from 19__ to _____, 19__

I last saw h. _____ alive on _____, 19__ Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Hypostatic Pneumonia
Emphysema
Date of onset _____

Other contributory causes of importance: 107a

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19__

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify (Signed) John W. Robertson, M. D.
(Address) Buchanan, Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PROPERTY OF MISSOURI STATE BOARD OF HEALTH. EXACT STATEMENT OF OCCURRENCE IS VERY IMPORTANT.

MAY 19 1949

S-2585