

**FILED APR 12 1940**  
Registration District No. **399**

Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Lakeside Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County \_\_\_\_\_  
(c) City or town Toronto  
(If outside city or town limits, write "RURAL")  
(d) Street No. Lakeside Hospital  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Lillian Elizabeth Rogers **262**  
Lillian E. Elizabeth Rogers

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec. 12, 1920  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
19 2 25 hr. min.

9. Birthplace Greenwood Co., Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Phillip L. Rogers

13. Birthplace Blue Mound Kansas  
(City, town, or county) (State or foreign country)

14. Maiden name Lillian Curtis

15. Birthplace Maple Hill, Kansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Lillian Rogers  
(b) Address Toronto, Kansas

17. (a) Removal (b) Date thereof 3-12-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Toronto, Kansas

18. (a) Signature of funeral director W. L. Grufe

(b) Address Clutha, Kansas

19. (a) Mch 10, 1940 (b) M. M. Browne  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9  
year 1940 hour 5 15 minute P. M.

21. I hereby certify that I attended the deceased from March 8, 1940, to March 9, 1940; that I last saw her alive on March 9, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Sho

Due to Local tonsillectomy  
at 9 30 a.m. 3-9-40

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury !

23. Signature A. B. Brites (M. D. or other)  
Address 512 Bryant Bldg Date signed 3-9-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**