

FILE MAY 27 1940

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

15660
Do not use this space.

1. PLACE OF DEATH
(a) County Osage Registration District No. 643
(b) Township Jefferson Primary Registration District No. 538 Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(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 John D. Rogers
(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) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alice Rogers
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 22, 1866.
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 9 4
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) (STATE OR COUNTRY) Belle, Mo.
13. NAME Martin Rogers
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.
15. MAIDEN NAME Mahala Gaither
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
17. INFORMANT Mrs. Ray Gawer (ADDRESS) Belle, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty Cem. DATE March 28, 1940
19. FUNERAL DIRECTOR S. G. Licklider (ADDRESS) Belle, Mo.
20. FILED May 10, 1940 Mrs. Jean Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 26, 1940
22. I HEREBY CERTIFY, That I attended deceased from Mar 23, 1940, to Mar 26, 1940
I last saw him alive on Mar 26, 1940 Death is said to have occurred on the date stated above, at 2.30 a.m.
The principal cause of death and related causes of importance were as follows:
apoplexy
Date of onset 3-23
Other contributory causes of importance:
92 W
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ 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) W. G. Johnson M. D.
Address Belle Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

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STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.
No..... or by....., Registered Apprentice No.....
working under my personal supervision.

Signed

Licensed Embalmer No.....

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-660

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 643

Primary Registration District No. 5832

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Jefferson
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community. years, months or days)

3. (a) PRINT FULL NAME John D. Rogers
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. year
7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 4 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.

18. (a) Signature of funeral director (b) Address

19. (a) June 11/1940 (Date received local Registrar) (b) W. G. Johnson (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Marion Co.
(c) City or town Belle Mo. (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

20. DATE OF DEATH: Month May day 26 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death.

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 W. G. Johnson (M. D. or other) Address Belle Mo. Date signed

SUPPLEMENTAL COPY

