

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

26065

Do not use this space.

1940
G. 23

1. PLACE OF DEATH
 (a) County Randolph Registration District No. 735
 (b) Township Wagon Creek Primary Registration District No. 3032 Registered No. 146
 (c) City Knoblocheux (d) Street No. McCormick Hospital 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? 53 yrs. 4 mos. 2 ds.

2. PRINT FULL NAME Annie Rogers
 (a) Residence, No. Salisbury Route 2 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

6A. IF MARRIED, WIDOWED, OR DIVORCED: HUSBAND OF (OR) WIFE OF Walker Rogers

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 16, 1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 53 4 2

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
 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) July 6, 1940
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Salisbury, MO
Chariton

FATHER
 13. NAME Julius Kaufmann

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

MOTHER
 15. MAIDEN NAME 7

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

17. INFORMANT (ADDRESS) Walker Rogers
Salisbury, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Wagon Valley DATE July 21, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Paul H. Rankney
924 W. E. Hall

20. FILED July 19, 1940 Arnell Butler
Deputy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 18, 1940

22. HEREBY CERTIFY, that Annie Rogers deceased from 7/18/40 to 7/18/40, 1940

I last saw her alive on 7/18/40, 1940. Death is said to have occurred on the date stated above, at 10:30 p.m.

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

Acute Intestinal Obstruction 7/17/40
 Date of onset

Other contributory causes of importance:
Jejunum Carcinoma

Name of operation Cholecystectomy Date of 7/18/40

What test confirmed diagnosis? As 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? No
 If so, specify _____

(Signed) W. H. Rankney M.D., M. D.
925 (Address) McCormick Hospital

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 impo

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RECEIVED

District Health Officer No. 10

District File Number 8-40-1580

Date Filed AUG 8 1940

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 C. L. Ireland
Licensed Embalmer No. 1399
P. O. Address Hyattsville

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26065-**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **735-**

Primary Registration District No. **3034**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Randolph**
(b) City or town **Proctor**
(If outside city or town limits, write "RURAL" and name of township)
(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..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (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.

3. (a) PRINT FULL NAME

Annie Rogers

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex **F**

5. Color or race **w**

6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years **53** Months **4** Days **2** 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)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) **July 19-40** (b) **Leah Williams** (Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month **18th** day **July** year **1940** hour **10** minute **30 P.** 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.....

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..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTAL CERTIFICATION

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26065-
Registrar's No. 142

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 735-

Primary Registration District No. 3034

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

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town mobility
(If outside city or town limits, write "RURAL" and name of township)
(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 Annie Rogers

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 4 2 _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year _____ 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 acute intestinal obstruction Duration _____

Due to 58

Due to _____

Other condition Generalized Carcinoma
(Include pregnancy within 3 months of death)

Major findings of operations N. M. D. II

Of autopsy _____

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 _____ (M. D. or other)

Address _____ Date signed _____