DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
APR 11 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10265

Registration District No. 125 Primary Registration District No. 3009 Registrar's No. 94

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francis Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 day (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott

(c) City or town Fornfelt (If outside city or town limits, write "RURAL")

(d) Street No. 1 (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Stella Mae Rogers

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Thomas C Rogers

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Mar. (Month) 19. (Day) 1896 (Year)

8. AGE: Years 44 Months 11 Days 15 If less than one day hr. min.

9. Birthplace Chrittondon Co (City, town, or county) Ky 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Gillie ~~Belt~~

FATHER
12. Name ~~Gr~~ Gillie Belt
13. Birthplace Chrittondon Co (City, town, or county) Ky 1 (State or foreign country)

MOTHER
14. Maiden name Mollie Agent
15. Birthplace Chrittondon Co (City, town, or county) Ky 1 (State or foreign country)

16. (a) Informant's own signature J C Rogers

(b) Address Fornfelt Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-41 (Month) (Day) (Year)

(c) Place: burial or cremation Bhodgett Cem.

18. (a) Signature of funeral director Buplinghoff & Hubbard

(b) Address Illmo Mo

19. (a) 3-4-41 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day March year 1941 hour 8 minute 4 M.

21. I hereby certify that I attended the deceased from 2/26, 1941, to 3/4, 1941 that I last saw her alive on 3/3, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis Following Rupture Gall bladder

Due to Cholecystitis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 121

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? 121 (Specify type of place)

While at work? (e) Means of injury

23. Signature O L Seabaugh (M. D. or other)

Address Cape Girardeau Mo Date signed 3/4/41

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 I X19511

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.

. No. 2
—1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10265

Registration District No. 125 Primary Registration District No. 3009 Registrar's No.

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape Girardeau
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Stella Mae 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 M
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 44 Months 11 Days 15 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTAL

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 4 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Peritonitis	
following Rupture of Gall Bladder	
Due to: Cholecystitis	
Due to: Acute and Chronic Gall Bladder	
Other conditions: Anemia Diet Deficiency	
(Include pregnancy within 3 months of death) No Stones	

Major findings:
Of operations
Of autopsy 27a

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature O. Lerbach (M. D. or other)
Address Cape Girardeau Date signed

(Licensed Embalmer's Statement on Reverse Side)

S-10265 1941

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.....,

vorking 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, fact should be so stated above.