

ED APR 3 1941

Registration District No. 317

Primary Registration District No. 5437

Registrar's No.

1. PLACE OF DEATH:

(a) County Greene Co.
(b) City or town Billings, Mo Rt 2
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 pond creek
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
(c) City or town Billings, Mo Rt 2
(If outside city or town limits, write "RURAL") Rural
(d) Street No. North of Billings mo
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5
year 1941 hour 9:00 PM minute _____ M.
21. I hereby certify that I attended the deceased from 2-3-41
_____, 19____, 2/4/41, 19____;
that I last saw him alive on 2/4/41, 19____;
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death _____
Due to Diagnosed from fluid in lung.
Due to _____

Other conditions _____
(Include pregnancy within 5 months of death)

Major findings:
Of operations _____

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? _____

23. Signature W. R. Mitchell (Specify type of placard) _____ (M., D., or other) _____
Address Republic Mo Date signed 2/4/41

8. (a) PRINT FULL NAME Infant of Mr & Mrs Wayne Rodgers
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M. 5. Color or race W. 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 February 3 1941
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Wayne Rodgers
13. Birthplace Missouri _____ (City, town, or county) (State or foreign country)
14. Maiden name Blades Claudia
15. Birthplace Missouri _____ (City, town, or county) (State or foreign country)

16. (a) Informant Wayne Rodgers

(b) Address Billings, Mo

17. (a) Burial (b) Date thereof Feb 6 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blades Chapel

18. (a) Signature of funeral director Wallace Funeral Home

(b) Address Billings, Mo

19. (a) Feb 5 (b) Mrs Bertha Nance
(Date received local registrar) (Registrar's signature)

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

RECEIVED

Greene County Health Office,

Case No. 41-3-34

Date 3/12/41

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.

Registration District No. 317

Primary Registration District No. 2437

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Pond Creek T. P.
(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 _____
In this community _____
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(d) Street No. _____
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Infant of Mr. & Mrs. Wayne R. Roger
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 s
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
2 hr. min.

9. Birthplace Greene Co Mo. (U.S.A.)
(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) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb. 5 (Date received local registrar) (b) Mrs Bertha Nance (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5
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.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____

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 B. C. Mitchell (M. D. or other) _____

Address Republic Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

TEMPORARILY

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

MOTHER FATHER

1941
S-10745

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, fact should be so stated above.