

Registration District No. 299

Primary Registration District No. 1002

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: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 mos 6 days  
15 years (Specify whether years, months or days)  
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 4523 Montgall  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21  
year 1941 hour 9 minute 2 M.

21. I hereby certify that I attended the deceased from 1-1940 to 5-21-1941  
that I last saw her alive on 5/21/41  
and that death occurred on the date and hour stated above.

Immediate cause of death: General carcinoma of liver and abdomen  
Due to

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy: no

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: D. R. Russell (M. D. or other)  
Address: 3011. 4. 2nd Ave. Date signed: 5/29/41

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Anna E. Rogerson

3. (b) If veteran, name war --- (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 John T. Rogerson 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased Nov 26, 1885 (Month) (Day) (Year)

8. AGE: Years 55 48 Months 5 Days 25 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER

12. Name No Record

13. Birthplace No Record 9 (City, town, or county) (State or foreign country)

14. Maiden name No Record (City, town, or county) (State or foreign country)

15. Birthplace No Record 9 (City, town, or county) (State or foreign country)

16. (a) Informant John T. Rogerson

(b) Address 4523 Montgall

17. (a) Burial (b) Date thereof 5/24/41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cem.

18. (a) Signature of funeral director J. E. & F. H. Co.

(b) Address P. O. Box

19. (a) May 24 1941 (b) M. H. Brown (Date received local registrar) (Registrar's signature)

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

46

**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 Harold Perry  
Licensed Embalmer No. 4897  
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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 17379

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 2041

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(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 Anna E Rogerson

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

4. Sex FE 5. Color or race Wh 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 55 Months Days If less than one day hr 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) 5/24/41 (b) M. M. Crow  
(Date received local registrar) (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 May day 21  
year 1941 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.....  
General carcinoma  
of liver + abdomen  
Due to.....  
laboratory test failed  
Due to.....  
to reveal primary cause

Other conditions.....  
(Include pregnancy within 3 months of death) 4/6/41

Major findings:  
Of operations..... 4/6/41

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?

(Specify type of place)  
While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....

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

SUPPLEMENTARY

S-17379