

FILED JAN 30 1942

Registration District No. 713Primary Registration District No. 6020-9Registrar's No. 88

## 1. PLACE OF DEATH:

- (a) County St. Francois  
 (b) City or town Bonne Terre  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1

(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 days3. (a) PRINT FULL NAME JAMES ROBERT RODGERS3. (b) If veteran,  
name war 3. (c) Social Security  
No. 4. Sex Male 5. Color or race White 6. (a) Single, widowed, married,  
divorced Widowed6. (b) Name of husband or wife Cora Ann Rodgers 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased October 1 1878  
(Month) (Day) (Year)8. AGE: Years 63 Months 2 Days 30 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Bonne Terre Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Retired

## 11. Industry or business

12. Name Joseph Rodgers13. Birthplace Missouri  
(City, town, or county) (State or foreign country)14. Maiden name Mary Harper15. Birthplace Missouri  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mrs. Cecelia Jones(b) Address St. Louis, Mo.17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1942  
(Month) (Day) (Year)(c) Place: burial or cremation Bonne Terre Cemetery18. (a) Signature of funeral director Bentley & Co.(b) Address 313 Benton Bonne Terre Mo.19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Data received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois(c) City or town Bonne Terre  
(If outside city or town limits, write "RURAL")(d) Street No. Mound  
(If rural, give location)

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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31 at  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_  
that I last saw him alive on Nov. 1940, to Dec. 4, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Pulmonary hemorrhage,  
uraemic  
Due to Pulmonary tuberculosis 2 yr.

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)Major findings: 1361  
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)  
(a) Means of injury \_\_\_\_\_23. Signature H. W. Roehrer (M. D. or other) M. D.Address Bonne Terre, Mo. Date signed 1/2/42

RECEIVED

District Health Officer No. 4

District File Number 142-75

Date Filed 1-13-42

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, and

Leonard John Vargo, Registered Apprentice No. 311,  
working under my personal supervision.

Signed

C. J. Claywell

Licensed Embalmer No.

3706

P. O. Address

Laurel Lane Mo

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.

STANDARD CERTIFICATE OF DEATH

State File No. 3401  
Registrar's No. ....

Registration District No. 775

Primary Registration District No. 6020-a

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

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Bonne Terre  
(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 James R. Rodgers

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 w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct (Month) 1 (Day) 1941 (Year)

8. AGE: Years 63 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ 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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

(c) (a) Jan 8 - 1942 (b) Dr. N. W. Hawkins  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

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

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

S-3401