No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 11 1942 128

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

Dr. Pickens 40792

State File No.

Registrar's No. 878

39
2
6

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

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: City Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 4 Months
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 39

(a) State Missouri (b) County Greene 2

(c) City or town Springfield 6
(If outside city or town limits, write "RURAL")

(d) Street No. 2100 W. Lincoln
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Janet Rogers

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife None

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

7. Birth date of deceased August (Month) 2 (Day) 1942 (Year)

8. AGE: Years	Months	Days	If less than one day
✓ 0	4	7	hr. min.

9. Birthplace Springfield (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Jack Rogers
13. Birthplace Ft. Scott (City, town, or county) Kansas 1 (State or foreign country)

MOTHER
14. Maiden name Alma Carsten
15. Birthplace Springfield (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Jack Rogers
(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 11, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Jones Cemetery

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 12-11-42 (Date received local registrar) (b) Dr W.E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9
year 1942 hour 10 minute 35 p. M.

21. I hereby certify that I attended the deceased from ..... 19..., to 12-9-'42 19...;
that I last saw her alive on 12-9-'42 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchi - Pneumonia ✓	48 Hrs
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)
(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 [signature] (M.D., or other)
Address 331 St. Louis St. Springfield Date signed 12-10

984 (Licensed Embalmer's Statement on Reverse Side) Springfield, Mo

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 L Doolan-Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
1—8-21-41
I X29288

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. 40792

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 878

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield
(If outside city or town limits write "RURAL" and name of township)
(c) Name of hospital or institution: City Hosp
(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: 4 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Greene
(c) City or town: Springfield
(If outside city or town limits, write "RURAL")
(d) Street No.: 2100 West Lincoln
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Janet 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: S
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Aug 2 — 1942 (Month) (Day) (Year)
8. AGE: Years 0 Months 4 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: Jack Rogers
13. Birthplace: (City, town, or county) Kansas (State or foreign country)
14. Maiden name: Alma Carslen
15. Birthplace: (City, town, or county) Mo (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9 year 1942 hour 0 1 5 minute a.m. p.m. 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.

	Duration
Immediate cause of death: Bronchopneumonia	3 Days
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 101	
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) (e) Means of injury .....
23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....