

Registration District No. 1614

Primary Registration District No. 5601

Registrar's No. 79

1. PLACE OF DEATH:  
 (a) County Johnson  
 (b) City or town Warrensburg, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
5 County Farm  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7 days  
(Specify whether  
 In this community all life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Johnson  
 (c) City or town Warrensburg, Missouri  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 401 Hamilton St.  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Martha R. Rogers

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced 3 divorced

6. (b) Name of husband or wife Dess Rogers 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased 12 30 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
54 6 13 hr. \_\_\_\_\_ min.

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

10. Usual occupation Sales Lady

11. Industry or business \_\_\_\_\_

12. Name Samuel Christian

13. Birthplace Holden Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Lawrence

15. Birthplace Holden Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs C. E. Atchison

(b) Address Chilhowee, Missouri

17. (a) Burial (b) Date thereof July 27, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director J. R. [unclear]

(b) Address Warrensburg, Mo

19. (a) July 29 '43 (b) Leola M. Williams  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27  
 year 1943 hour 5 minute 30 M.

21. I hereby certify that I attended the deceased from July 26 43  
 to July 27 43 1943  
 that I last saw h. alive on July 26 1943  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Stomach  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to H6 f  
 Other conditions none  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations none  
 Of autopsy none  
 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 Wm. Patterson (M. D. or other) \_\_\_\_\_  
 Address Warrensburg, Mo Date signed 7-29-43

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 8-4-43

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 No Embalming

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.

FILED AUG

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3 8  
Registrar's No. 79

Registration District No. 164

Primary Registration District No. 5601

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

1. PLACE OF DEATH:

(a) County Johnson  
(b) City or town Warrensburg Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution County Farm  
(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

Matha P. 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 al

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Dec 30  
(Month) (Day) (Year)

8. AGE: Years 54 Months 6 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 \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Paul M. Williams  
(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 July year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ 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)

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

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

