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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 13 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18430

Registration District No. 166

Primary Registration District No. 5605

Registrar's No. 9

1. PLACE OF DEATH

(a) County Johnson

(b) City or town Knob-Norris Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Hitchcock
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 m
(Specify whether P)

In this community 40 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Johnson

(c) City or town Knob-Norris Rural
(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 _____

3. (a) PRINT FULL NAME JENNIE AKINS ROGERS

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

4. female 5. Color or race white

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

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

7. Birth date of deceased July 10 - 1882
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1944 hour 8 minute 35A.M.

21. I hereby certify that I attended the deceased from May 25
1944 to May 25, 1944
that I last saw her alive on May 25, 1944
and that death occurred on the date and hour stated above.

8. AGE: 91 Years 10 Months 15 Days
If less than one day _____ hr. _____ min.

Immediate cause of death
(1) Coronary Occlusion

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 94a

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

10. Usual occupation Ret. House wife

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy _____

MOTHER FATHER

16. (a) Informant Mrs Harry Hume
(b) Address Knob-Norris Mo.

17. (a) Burial (b) Date thereof May 26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Grove

18. (a) Signature of funeral director C. Saults
(b) Address Knob-Norris Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 John Hume M.D. M. D. or other _____
Address Knob-Norris Mo. Date signed May 29

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

66

1346

(Licensed Embalmer's Statement on Reverse Side)

1944

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.....

C. L. Saults

....., Registered Apprentice No.

working under my personal supervision.

Signed *C. L. Saults*

Licensed Embalmer No. *1086*

P. O. Address *Knob Hoster N*

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.

Registration District No. 166

Primary Registration District No. 5605

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Rural Washington
(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 Jennie Akins 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 W

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

7. Birth date of deceased July 10 1891
(Month) (Day) (Year)

8. AGE: Years 91 Months 10 Days _____ If less than one day _____ min.

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

10. Usual occupation Ret. Housewife

11. Industry or business _____

12. Name Robert Akins

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

14. Maiden name Ellen

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

16. (a) Informant Mrs. Harry Hume
(b) Address Knob Knoster Mo.

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof May 26-44
(Month) (Year)

(c) Place: burial or cremation Pleasant Place C. S. Smith

18. (a) Signature of funeral director Knob Knoster Mo.
(b) Address _____

19. (a) May 26-44 (b) Mrs. Edith Auld
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Johnson
(c) City or town Rural
(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 _____ day _____ year _____ 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 Coronary Occlusion

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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 G. W. Shaw (M. D. or other) _____
Address Knob Knoster Mo. Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

18430