

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14738

FILED APR 21 1945

Primary Registration District No. 6190

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Trigg

(b) City or town Licking  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Henry A Rodgers

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 19 year 1945 hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from 15 1945 to Mar 19 1945; that I last saw him alive on Mar 19 1945; and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nora Rodgers 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Sept 17 1865  
(Month) (Day) (Year)

Immediate cause of death Double broncho pneumonia Duration \_\_\_\_\_

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

8. AGE: Years 79 Months 6 Days 2 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

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

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Farming

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

12. Name Jacob B Rodgers

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

14. Maiden name not known

15. Birthplace not known  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy 107

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant J B Rodgers

(b) Address Licking Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Licking Cem

18. (a) Signature of funeral director Walter Ferguson

(b) Address Licking Mo

19. (a) 448-45 (b) Maggie Wilson  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(c) 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) (Means of injury)

23. Signature W H Reed (M.D. or other) \_\_\_\_\_

Address Licking Date signed 3/20/45

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

1237

RECEIVED

District Health Officer No. 5,

District File Number

445-214

Date Filed

7.24.45

OCT 1 1945

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

*Embert E Ferguson*

Licensed Embalmer No.

3945

P. O. Address

*Licking, Md*

**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.**