

FILED DEC 8 1945
Registration District No. **53**

Primary Registration District No. **3010**

Registrar's No. **368**

1. PLACE OF DEATH:

(a) County **Cape Girardeau**
(b) City or town **Cape Girardeau**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Francis Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
(Specify whether
In this community **4 days**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid**
(c) City or town **Rural New Madrid**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **9**
year **1945** hour **11.6** minute **30** A.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.

Immediate cause of death: **TETANUS**
Due to **POST-OPERATIVE**

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?
Will work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature **H. W. Albritton** (M. D. or other) **MD**
Address **Cape Girardeau** Date signed **11/10/45**

3. (a) PRINT FULL NAME **Annie May Rogers**

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

4. Sex **F** 5. Color or race **C** 6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **Arthur Rogers** 6. (c) Age of husband or wife if alive **23** years

7. Birth date of deceased **12 24 1923**
(Month) (Day) (Year)

8. AGE: Years **22** Months **11** Days **9** If less than one day hr. _____ min. _____

9. Birthplace **Unknown La. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming Labor**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown**

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

14. Maiden name **Ida Reath**

15. Birthplace **Unknown La. 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Arthur Rogers**

(b) Address **Matthews, Mo. R.F.D. # 1**

17. (a) **Burial** (b) Date thereof **11/11/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sikeston, Mo.**

18. (a) Signature of funeral director **H. W. Albritton**

(b) Address **Sikeston, Mo.**

19. (a) **11-12-1945** (b) **O. G. Summer**
(Date received local registrar) (Registrar's signature)

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

241
17-39
X28390

RECEIVED

District Health Officer No.

District File Number 1245-1

Date Filed 12-6-45

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.....

not embalmed

....., Registered Apprentice No.

working under my personal supervision.

Signed

Hunter Albritton

Licensed Embalmer No. 4210

P. O. Address Sikeston, Mo.

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

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

Registration District No.

53

Primary Registration District No.

2010

Registrar's No.

368

1. PLACE OF DEATH:

(a) County *Cape Girardeau*
(b) City or town *Cape Girardeau*
(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 *Annis M. Roger*

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

4. Sex *F* 5. Color or race *C* 6. (a) Single, widowed, married, divorced *M*

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

7. Birth date of deceased *Dec 24 1924*
(Month) (Day) (Year)

8. AGE: Years *22* Months *11* Days *2* (if less than one day) hr. min.

9. Birthplace *La*
(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) (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)

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* year *1945* hour *12* minute *00* M.

21. I hereby certify that I attended the deceased from *12/24/45* to *12/24/45*, 19.....; that I last saw him/her alive on *12/24/45*, 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to *No. Accident.*

Other conditions (include pregnancy within 3 months of death).....

Major findings: Of operations.....

Of autopsy.....

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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) *NONE*

(b) Date of occurrence *NONE*

(c) Where did injury occur? *NONE*
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *NONE*

While at work? (Specify type of place)

(e) Means of injury *NONE*

23. Signature *A. Smith* (M. D. or other) *MD*

Address *Cape Girardeau* Date signed *12/24/45*

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

SUPPLEMENTARY

30836