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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

223318

# FILED AUG 2 1946 STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. 598

Registration District No. 128

Primary Registration District No. 2000

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:  
1840 S. Jefferson  
(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 Missouri (b) County Greene

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

(d) Street No. 1840 So. Jefferson  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN BARTLEY ROGERS

3. (b) If veteran, name war U.N.K.

3. (c) Social Security No. U.N.K.

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Sylvia Rogers (wife)

6. (c) Age of husband or wife if alive U.N.K. years

7. Birth date of deceased February 26, 1871  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>75</u>	<u>4</u>	<u>19</u>	.....hr. ....min.

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

10. Usual occupation Railroad clerk

11. Industry or business Frisco Railroad

MOTHER FATHER { 12. Name Wm. Oliver Rogers

13. Birthplace U.N.K. Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Bartley

15. Birthplace U.N.K. Ohio Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sylvia Rogers

(b) Address 1840 S. Jefferson, S.P.F.D., Mo.

17. (a) Removal (b) Date thereof July 16, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Havanna, Illinois

18. (a) Signature of funeral director ALMA LOHMEYER FUNERAL HOME

(b) Address 534 St. Louis St. Springfield, Mo.

19. (a) 7-16-46 (b) W. S. Handley  
(Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15  
year 1946 hour 10 minute 40 A. M.

21. I hereby certify that I attended the deceased from April 3, '46 19 to 7/15/46 19;  
that I last saw h. im alive on 7/15/46 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio-sclerosis  
Duration ?

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

Other conditions 97  
(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)  
(c) Means of injury \_\_\_\_\_

23. Signature J. B. Lemmon (M. D. or other) O. M. A.  
Address Springfield, Mo. Date signed 7/16/46

AUG 2 1949

SEP 11 1949

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. A. Roof*

Licensed Embalmer No. 3044

P. O. Address.....

*Springfield, Mo.*

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.

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