

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37840

State File No. _____

FILED DEC 6 1946

Registration District No. 249

Primary Registration District No. 4370

Registrar's No. 171

1. PLACE OF DEATH:

(a) County Nodaway
 (b) City or town Clearmont, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
north edge of town
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 60 Years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Louisa Jane Rogers

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife Thomas Rogers 6. (c) Age of husband or wife if alive deceased years
 7. Birth date of deceased June 17, 1857
 (Month) (Day) (Year)

8. AGE: Years 89 Months 4 Days 21 If less than one day
 hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business None

12. Name Thomas Wallace
 13. Birthplace Tenn.
 (City, town, or county) (State or foreign country)
 14. Maiden name HIBBS
 15. Birthplace Tenn.
 (City, town, or county) (State or foreign country)

16. (a) Informant Kenneth Rogers
 (b) Address Clearmont, Missouri
 17. (a) Burial (b) Date thereof 11/11/46
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Clearmont Cemetery

18. (a) Signature of funeral director Price Funeral Home
Maryville, Missouri
 (b) Address
 19. (a) Nov 30 - 46 (b) Bess Halt
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway 74
 (c) City or town Clearmont
 (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 Nov. day 8th
 year 1946 hour 10:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from
October 19 46 to Nov 8 19 46
 that I last saw h. alive on Nov 8 19 46
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebro-vascular accident
 Duration minutes
 Due to Smility

Due to _____
 Other conditions (Include pregnancy within 3 months) _____

Major findings: Of operations **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
 Of autopsy Malignancy in small intestine metastatic
 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? 21

(Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature Maxwell Ford (M. D. or other) MD
Clearmont Date signed 11-15-46

229 (Licensed Embalmer's Statement on Reverse Side)

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

3003

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Clay M. Price

Licensed Embalmer No. 1822

P. O. Address Maryville, 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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 (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 Louisa J. Rogers
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex 2 5. Color or race w
 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased June 17 1885
(Month) (Day) (Year)

8. AGE: Years 89 Months 4 Day 1
(If less than one day hr. min.)

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
 { 12. Name.....
 { 13. Birthplace Sen Sen
(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) 366-57 (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
 (b) Address.....

19. (a)..... (b).....
(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 Dec year 1946 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... 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 stroke of ailer

Due to.....
 Due to.....
 Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings: Of operations.....
 Of autopsy Card. originating in myocardial attachment
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.....

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

SUPPLEMENTARY

37840