

S. No. 2
-12-45
5-17-39
PI X47070

FILED MAY 22 1947
Registration District No. **176**

Primary Registration District No. **3026**

Registrar's No. **135**

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

1. PLACE OF DEATH:
 (a) County **JACKSON**
 (b) City or town **INDEPENDENCE**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
RESIDENCE : 943 S. NOLAND /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community **38 YEARS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **MRS. ANNA RODGER**
 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. **WIDOWED**
 6. (b) Name of husband or wife **JOSEPH B. RODGER**
 6. (c) Age of husband or wife if alive. **XXX XX** years
 7. Birth date of deceased **8 22 1862**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 8 11 hr. min.

9. Birthplace **NEAR SAGINAW MICH**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE**

11. Industry or business **NONE**

MOTHER FATHER { 12. Name **ISAAC BOGUE**
 13. Birthplace **BRUNSWICK OHIO**
(City, town, or county) (State or foreign country)

{ 14. Maiden name **SARAH E. WILTSE**
 15. Birthplace **SAGINAW MICH**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. SADIE HARTSHORN**
 (b) Address **943 S. NOLAND**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **5-6-47**
(Month) (Day) (Year)
 (c) Place: burial or cremation **MOUND GROVE**

18. (a) Signature of funeral director **W. Stahl**
 (b) Address **815 W. MAPLE AVE.**

19. (a) **5-10-47** (Date received local registry) (b) **James E. Lind** (Registrar's signature) **2-11-47**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **JACKSON** **48**
 (c) City or town **INDEPENDENCE** **4**
(If outside city or town limits, write "RURAL")
 (d) Street No. **943 S. NOLAND** **4**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No) **0**
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **3**
 year **1947** hour **7** minute **00** P.M.

21. I hereby certify that I attended the deceased from **7/1** 19**46** to **5/3** 19**47**;
 that I last saw her alive on....., 19.....;
 and that death occurred on the date and hour stated above.

Immediate cause of death. **Cerebral hemorrhage** **10 min**
 Due to **arteriosclerosis** **yes**
hypertension **yes**
 Other conditions (Include pregnancy within 3 months of death)
 Major findings: **g n p**
 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) (e) Means of injury **0**
 23. Signature **James E. Lind, M. D.** (M. D. or other) **1**
 Address **129 W. Lexington, Independence, Mo.** Date signed **5/5/47**

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.....


Licensed Embalmer No. 3156

P. O. Address Indep. 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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