

2. No. 2  
-12-45  
5-17-39  
PI X4 60

**FILED AUG 19 1947**

Registration District No. **360**

Primary Registration District No. **6225**

Registrar's No. **135**

**1. PLACE OF DEATH:**

(a) County **Vernon**

(b) City or town **Wheat Washington Mo.**

(c) Name of hospital or institution: **State Hospital #37**  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution. **1 yr 10 mo**  
(Specify whether years, months or days)

In this community **1 Year 10 Months**  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo**

(b) County **Vernon**

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

(d) Street No. **700 So Pine**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.

**3. (a) PRINT FULL NAME: RUSSELL ROGERS**

3. (b) If veteran, name war **L**

3. (c) Social Security No. **L**

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Aug** day **5**  
year **1947** hour **7** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **5-12-1947** to **8-5-1947**  
that I last saw him alive on **8-5-1947**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration

4. Sex **M D**

5. Color **W**

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

6. (b) Name of husband or wife **Aylvia Rogers**

6. (c) Age of husband or wife if alive **37** years

7. Birth date of deceased **6-27-1899**  
(Month) (Day) (Year)

Due to

Due to

Other conditions **Heart**  
(Include pregnancy within 3 months of death)

**8. AGE:**

Years	Months	Days	If less than one day
<b>55</b>	<b>1</b>	<b>8</b>	hr. min.

9. Birthplace **Ind. Indiana**  
(City, town, or county) (State or foreign country)

**PHYSICIAN**

Major findings: **Heart**

Of operations **Heart**

Of autopsy **Heart**

Underline the cause to which death should be charged statistically.

10. Usual occupation **Tractor**

11. Industry or business **Tractor**

**MOTHER FATHER:**

12. Name **George Rogers**

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

14. Maiden name **Agnes Spahr**

15. Birthplace **Ind. Indiana**  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant **Hospital record**

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

17. (a) **Funeral** (Burial, cremation, or removal)

(b) Date thereof **8-8-47**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Nevada Burial Park**

18. (a) Signature of funeral director **Erubigin Zimmell**

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

19. (a) **8-9-47** (Date received local registrar)

(b) **Ruthyn Spence** (Registrar's signature)

23. Signature **W. H. Hall** (M.D., pathologist)

Address **Nevada Mo** Date signed **8/15/47**

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

RECEIVED  
District Health Officer No. 7,  
7-47-976  
District File Number 8-18-47  
Date Filed

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.....

*Richard Lee Shorter* - ....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Mark C. Eubinger*  
Licensed Embalmer No. *2656*

P. O. Address *Wvada, 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.