

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

U.S. DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 17 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **44233**

Registration District No. **101**

Primary Registration District No. **5397**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **DOUGLAS, Bryan Twp.**  
(b) City or town **VANZANT (RURAL)**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **NO**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community **LIFE TIME**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **DOUGLAS 34**  
(c) City or town **VANZANT (RURAL)**  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME

**Ethel Wanda Rodgers**

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 **MARRIED!**  
6. (b) Name of husband or wife **CHARLIE RODGERS** 6. (c) Age of husband or wife if alive **40** years  
7. Birth date of deceased **Feb 16, 1909**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>37</b>	<b>9</b>	<b>28</b>	hr. _____ min. <b>0</b>

9. Birthplace: **Heboen, Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

12. Name **NICK Clinton** **0**

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

14. Maiden name **VILDA ANN PRUITT** **0**

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

16. (a) Informant **CHARLIE Rodgers**

(b) Address **MET. GRACE - VANZANT MO.**

17. (a) **BURIAL** (b) Date thereof **12/6/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **VANZANT MO.**

18. (a) Signature of funeral director **Russell Barber**  
(b) Address **Mt. Grove, Mo.**

19. (a) **1-29-48** (b) **Vestal Bushman**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **4**  
year **1947** hour **6** minute **7** P. M.

21. I hereby certify that I attended the deceased from **April 4, 1947** to **Dec. 4, 1947**  
that I last saw her alive on **Dec. 4, 1947**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Metastatic carcinoma of bowel.**

Duration

**1 year**

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

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **4/6**

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 **2**

23. Signature **Thomas T. Francisco** (M.D. or other) **D.O.**

Address **Willow Springs Mo.** Date signed **11-12-47**

RECEIVED

District Health Officer No. 6,

District File Number 148-55

Date Filed JAN 1 1948

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.....

working under my personal supervision.

Signed Russell Barber, Registered Apprentice No. ....

Licensed Embalmer No. 3848

P. O. Address New Hope, Pa.

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb  
Registrar's No. 88

Registration District No. 101

Primary Registration District No. 5397

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

1. PLACE OF DEATH:

(a) County Douglas

(b) City or town Rural  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Ethel W. Rodger

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

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 Feb 16  
(Month) (Day) (Year)

8. AGE: 37 Years Months Days  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

13. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) Jan 29-48 (b) Westal Bushman  
(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 \_\_\_\_\_ Day \_\_\_\_\_  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

SUPPLEMENTARY

44233