

BIRTH NO. _____

1. PLACE OF DEATH
a. COUNTY Jackson

b. CITY (If outside corporate limits, write RURAL and give township) Independence

c. LENGTH OF STAY (In this place) 3 Mo

d. FULL NAME OF HOSPITAL OR INSTITUTION Indep. Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY Jackson

c. CITY (If outside corporate limits, write RURAL and give township) Independence 1484

d. STREET ADDRESS (If rural, give location) 834 N Osage

3. NAME OF DECEASED (Type or Print)
a. (First) Elizabeth H. b. (Middle) Rogers c. (Last) _____

4. DATE OF DEATH (Month) (Day) (Year)
July 18, 1950

5. SEX Fe 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Jan 20 1883 9. AGE (In years last birthday) (Months) (Days) (If under 1 year) (Hours) (Mins.)
67

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) Richmond Ky 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Willis Hisle 13b. MOTHER'S MAIDEN NAME Martha Edith Covington Noah Weir 14. NAME OF HUSBAND OR WIFE Walter Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME Mrs William Gannon ADDRESS Indep Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of the Liver

ANTECEDENT CAUSES (b) Massive Thrombosis of Portal veins + Retrograde thrombosis of superior Mesenteric Vein + Infarction of Spleen

II. OTHER SIGNIFICANT CONDITIONS (c) 5810

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from May 16, 1950, to July 18, 1950, that I last saw the deceased alive on July 18, 1950, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE Harold V. Woods (Degree or title) M.D. 23b. ADDRESS Independence Mo 23c. DATE SIGNED July 29, 1950

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE July 20, 1950 24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem 24d. LOCATION (City, town, or county) (State) Independence, Mo

DATE REC'D BY LOCAL REG. July 19, 1950 REGISTRAR'S SIGNATURE [Signature] 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Independence Mo

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

1484

JUL 24 RECD

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.

Student Embalmer No.....

Signed

Marion A. [Signature]

Signed.....

Student Embalmer

Licensed Embalmer No. *3156*

P. O. Address *Independence, 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.