

FILED OCT 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30092

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BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5463 Registrar's No. 854

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY OR TOWN RURAL 2 nd JACKSON		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL 2 nd JACKSON 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION NEAR STRAFFORD MO.		d. STREET ADDRESS (If rural, give location) 2 MILES EAST OF STRAFFORD MO.	
3. NAME OF DECEASED a. (First) SARAH		b. (Middle) H.	
		c. (Last) ROGERS	
4. DATE OF DEATH		SEPT. 28 1950	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 3 DEC. 1874
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) MISSOURI 0
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME THOMAS ARCHER	
13b. MOTHER'S MAIDEN NAME MARTHA GREMM		14. NAME OF HUSBAND OR WIFE W.B. ROGERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME N.B. ROGERS		ADDRESS RT. 1 STRAFFORD	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardio-Renal-Vascular Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 8-23, 1950, to 9-28, 1950, that I last saw the deceased alive on 9-27, 1950, and that death occurred at 11:15 P.m., from the causes and on the date stated above.	
23a. SIGNATURE <u>Max Fitch</u>		23b. ADDRESS <u>Springfield Mo</u>	
23c. DATE SIGNED 9-29-50		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 9/30/50		24c. NAME OF CEMETERY OR CREMATORY MT. PISGAH CEMETERY	
24d. LOCATION (City, town, or county) (State) NEAR NORTHVIEW MO.		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Handley</u>	
DATE REC'D BY LOCAL REG. 9-29-50		REGISTRAR'S SIGNATURE <u>W.C. Handley</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Spunklingner & Co.</u>		ADDRESS <u>Springfield, Mo.</u>	

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

JAN 15 1953

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Ogilston Jr.

Licensed Embalmer No. 4126

P. O. Address Springfield

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.