

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29222**

FILED AUG 17 1951

BIRTH NO. _____ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3072** Registrar's No. **127**

003

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

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Scott	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston, Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston, Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 217 Mill Row Sikeston, Mo		d. STREET ADDRESS (If rural, give location) 217 Mill Row Sikeston, Mo	
3. NAME OF DECEASED (Type or Print) a. (First) James		b. (Middle) Bennett	
c. (Last) Rogers		4. DATE OF DEATH (Month) (Day) (Year) 8 3 1951	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 10/29/84
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months 9	IF UNDER 1 YEAR Days 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Willson Co Ill
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Steve Rogers	
13b. MOTHER'S MAIDEN NAME Carolyn Harris		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Charles W. Rose		ADDRESS Sikeston, Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Pulmonary Tuberculosis		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		ANTICIPATED CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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) Sikeston Scott Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from July 5, 1957 , to Aug 3, 1957 , that I last saw the deceased alive on 8-3, 1957 , and that death occurred at 4:30 p.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS Sikeston	
23c. DATE SIGNED 8-7-57		24a. BURIAL/CREMATION, REMOVAL (Specify) Burial	
24b. DATE 8/5/51		24c. NAME OF CEMETERY OR CREMATORY Freind Cemetery	
24d. LOCATION (City, town, or county) (State) Oran, Mo		25. GENERAL DIRECTOR'S SIGNATURE [Signature]	
DATE REC'D BY LOCAL REG. Aug 8-57		REGISTRAR'S SIGNATURE [Signature]	

RECEIVED AUG 13 1951

SCOTT COUNTY HEALTH CENT

CO. FILE NO. 851-1

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 John A. Stanton.....

Licensed Embalmer No. 2941.....

P. O. Address Stanton.....

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.