

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31526**

42215
FILED OCT 13 1953

BIRTH NO.		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>925-B</u>	
1. PLACE OF DEATH a. COUNTY <u>Dreame</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Douglas</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>1 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Bruan</u>		0340	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bunge Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Star Route 1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>GERALD</u>		b. (Middle) <u>DUANE</u>		c. (Last) <u>ROGUE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 29, 1953</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>		8. DATE OF BIRTH <u>June 25, 1953</u>	
9. AGE (In years last birthday) <u>3</u>		10. MONTHS <u>4</u>		11. HOURS <u>4</u>		12. MINUTES <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <input checked="" type="checkbox"/>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Wayne Rogue</u>		13b. MOTHER'S MAIDEN NAME <u>Myronne Towliam</u>		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>5703</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Myronne Rogue Bruan Mo.</u>			
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>Volvulus, & Peritonitis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Congenital Malrotation of Gut Birth</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
19a. DATE OF OPERATION <u>9/28/53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Volvulus, Peritonitis Resection of congenous bowel</u>				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) <u>Springfield, Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>9/28/53</u> 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 <u>9/28/1953</u> , to <u>9/29/1953</u> , that I last saw the deceased alive on <u>9/29/1953</u> , and that death occurred at <u>2:00 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Paul Busick M.D.</u>				23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>9/30/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-30-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Christian Co., Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-6-53</u>		REGISTRAR'S SIGNATURE <u>Edith Wallmann</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Ferrell</u>			
				ADDRESS <u>Fordland Mo.</u>			

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

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.....
M. K. Ferrell

Signed.....
Student Embalmer

Licensed Embalmer No. *4910*

P. O. Address *Fordland, 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.