

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010158  
STATE FILE NUMBER  
1318

FILED MAR 31 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City, Mo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lees Summit</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital</b>		Length of stay in lb <b>114</b> days	d. STREET ADDRESS (If outside, give location) <b>P.O. Box 11</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>T.</b> Last <b>ROGERS</b>			4. DATE OF DEATH Month <b>3rd</b> Day <b>10th</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-7-91</b>	9. AGE (In years last birthday) <b>66 yrs</b>	10. FUNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchandise Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Pittsburg, Pa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>William Rogers</b>		13b. MOTHER'S MAIDEN NAME <b>Esther Nickels</b>	
14. NAME OF HUSBAND OR WIFE <b>Marion Rogers</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>487-44-3172A</b>	
17. INFORMANT <b>V.A. Hospital Records, K. C., Mo.</b>		17. ADDRESS		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute bronchopneumonia of the middle and lower lobes</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5271'</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Pulmonary emphysema and fibrosis</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. <input checked="" type="checkbox"/> attended the deceased from <b>September 27, 1957</b> to <b>March 10, 1958</b> and was present on <b>September 27, 1957</b> on <b>September 27, 1957</b> at <b>9:45p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>ROBERT FLINNEY, M.D.</b> <i>Robert Flinney M.D.</i>			22b. ADDRESS <b>MD V.A. Hospital, Kansas City, Mo</b>		22c. DATE SIGNED <b>3-10-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>MAR. 12 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LEES SUMMIT CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>LEES SUMMIT MISSOURI</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>		ADDRESS <b>1731 BRUSH CREEK KANSAS CITY, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>3-12-58</b>	26. REGISTRAR'S SIGNATURE <i>neva minshall</i>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION



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 .....  
Signature of Student Embalmer

Signed *Herold B. Eckert*

Licensed Embalmer No. 3035

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.