

Dr. Lurie
FILED SEP 29 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032383
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 916

5. 300
1-57

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MISSOURI b. COUNTY COLE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN JEFFERSON CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSP.		d. STREET ADDRESS (If outside, give location) 216 PINE, ST.	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM DRYDEN ROGERS		4. DATE OF DEATH Month Day Year SEPT. 20 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 7 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR - STATE HIGHWAY DEPT.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) BATES COUNTY, MO.
13a. FATHER'S NAME J.M. ROGERS		13b. MOTHER'S MAIDEN NAME LUCY WILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, NO unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. CLAUD WOOD, MARSHFIELD, MO.		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) Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized Arteriosclerosis			
DUE TO (c) 332X			
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>9-17-58</u> to <u>9-20-58</u> and last saw ^{her} him alive on <u>9-19-58</u> Death occurred at <u>12:40 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Harold H. Lurie, M.D.		22b. ADDRESS 609 Cherry Springfield, Mo	
		22c. DATE SIGNED 9-22-58	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
REMOVAL		9/23/58	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
RIVERVIEW CEMETERY		JEFFERSON CITY, MO.	
24. FUNERAL DIRECTOR ADDRESS GORDON FUNERAL HOME JEFFERSON CITY MO.		25. DATE RECD. BY LOCAL REG. 9-22-58	
		26. REGISTRAR'S SIGNATURE Effie G. Melton	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related. No symptoms will be listed.

UNIVERSITY OF MICHIGAN

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 *A. J. McQuinn*

Licensed Embalmer No. *7727*

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