

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008793  
STATE FILE NUMBER

FILED MAR 31 1959

Registration District No. 74 Primary Registration District No. 4136 Registrar's No. \_\_\_\_\_

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Plattsburg</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Plattsburg</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>511 W. Osage</u>		Length of stay in lb <u>3 years</u>	d. STREET ADDRESS (If outside, give location) <u>511 W. Osage</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle _____ Last <u>ROGERS</u>			4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Switchman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Terminal Railroad</u>	11. BIRTHPLACE (City and state or country) <u>Plattsburg, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William F. Rogers</u>	13b. MOTHER'S MAIDEN NAME <u>Laura F. Hedges</u>	14. NAME OF HUSBAND OR WIFE <u>Jessie L.</u>
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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>712-01-5289</u>	17. INFORMANT <u>Mrs. Jessie Rogers Plattsburg, Mo.</u>	Address <u>511 West Osage</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ 4200		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>3 Mo</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Hemorrhage 1957</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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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 _____
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21. I attended the deceased from <u>March 1957</u> and last saw <sup>her</sup> him alive on <u>Mar. 14-1959</u> Death occurred at <u>7:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>W. B. Spalding MD</u>	22b. ADDRESS <u>Plattsburg Mo</u>	22c. DATE SIGNED <u>Mar 15-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/17/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>	23d. LOCATION (City, town, or county) <u>Plattsburg Mo.</u>	(State)
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24. FUNERAL DIRECTOR <u>Heaton-Bowman - St Joseph, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MARCH-23-59</u>	26. REGISTRAR'S SIGNATURE <u>Mary W Seance</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

APR 9 1959

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 *Eugene Wood* .....

Licensed Embalmer No. *3804* .....

P. O. Address *319 56th St. Joplin* .....

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.