

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 20 1960

-60-034000
STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 504

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| 1. PLACE OF DEATH a. COUNTY Butler | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff | | Length of stay in 1b 12yrs. | c. CITY OR TOWN Poplar Bluff Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION Lacy Lee Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) .83I Alice Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Nella Middle Augustine Last Rogers | | | 4. DATE OF DEATH Month Aug. Day 21 Year 1960 | | |
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|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|--|
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1/22/1891 | 9. AGE (last birthday) 79 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic (Retired) | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) New Orleans, La. | 12. CITIZEN OF WHAT COUNTRY U.s.a. |
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| 13a. FATHER'S NAME Albert Augustine | 13b. MOTHER'S MAIDEN NAME Mary Young | 14. NAME OF HUSBAND OR WIFE Doc V Rogers |
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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) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Wallace Augustin, New Orleans, La. |
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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) Cerebrovascular accident | | INTERVAL BETWEEN ONSET AND DEATH 42days | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Pneumonia | | 17 days |
| | DUE TO (c) Acute gastroenteritis | | 38 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis. | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | Month, Day, Year |
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|--|--|--|--------|-------|
| 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 Poplar Bluff, Mo. | COUNTY | STATE |
|--|--|--|--------|-------|

21. I attended the deceased from **7/11/60** to **8/21/60** and last saw ~~her~~ **her** on **8/21/60**
Death occurred at **10:10 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE John R. Loughhead, M.D. (Degree or title) | 22b. ADDRESS 330 N. 2nd St. - Poplar Bluff, Mo. | 22c. DATE SIGNED 8/31/60 |
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|---|-----------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 8/25/1960 | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY City Cemetery | 23d. LOCATION (City, town, or county) (State) Poplar Bluff, Mo. |
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| 24. FUNERAL DIRECTOR Peoples Funeral Home - Poplar Bluff | ADDRESS | 25. DATE REC'D. BY LOCAL REG. 9/5/60 | 26. REGISTRAR'S SIGNATURE R. M. ... |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wallace R. Knier

Licensed Embalmer No. 4514

P. O. Address 822 F. Poplar

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. Failure to do so 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.