MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DEC 22 1930

Do not use this space.

35884

File No.
Registered No. 883

1. PLACE OF DEATH
County Greene
Township
City Springfield (No. 1092 S Glenstone St. Ward)

Registration District No. 318
Primary Registration District No. 2001

2. FULL NAME Warren Chauncey Rogers
(a) Residence. No. 1092 S Glenstone St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S.

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) NOV 10 - 1929

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
1	0	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Springfield, Mo
(STATE OR COUNTY)

PARENTS
10. NAME OF FATHER H. J. Rogers
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTY) Unknown
12. MAIDEN NAME OF MOTHER Iris Chauncey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Walnut Grove
(STATE OR COUNTY) Mo

14. INFORMANT H. J. Rogers
(Address) Springfield, Mo

15. FILED 11-22, 1930 Ross Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 11 - 22 1930

17. I HEREBY CERTIFY, That I attended deceased from 11-22-, 1930, to 11-22-, 1930 that I last saw h. alive on 11-22-, 1930, and that death occurred, on the date stated above, at 11 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastric ulcer.
11 hrs
1 yr (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Hemorrhage 4 days
Acidosis (Starvation) (duration) 2 days yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Walnut Grove, Mo
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) Verlan J. Buist, M. D.
11-22, 1930 (Address) Springfield, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greenlawn Cem, Walnut Grove Mo
DATE OF BURIAL 11-23 1930

20. UNDERTAKER Gene Brim
ADDRESS Walnut Grove Mo.

N. B. Be carefully supplied. AGE should be stated EXACTLY. Blanks should state CAUSE of DEATH, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County ..... Registration District No. 318 ..... File No. .....

Township ..... Primary Registration District No. 2001 ..... Registered No. 883

City Springfield (No. ....., ... St. ..... Ward)

2. FULL NAME Warren Chauncey Rogers

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W.	D

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 11/22, 19 30 Don Shard
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11 - 22 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 ..... that I last saw h ..... alive on ..... 19 ..... and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastric ulcer
Non Diabetic
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Hemorrhage 4 days
Acidosis ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS MAY NOT ISSUE BURIAL PERMITS OR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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