

WATER-PROOF INK—USE DIVIDING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3954

Registration District No. 797

Primary Registration District No. 6040

Registrar's No. 1

1. PLACE OF DEATH: Saline
 (a) County Saline
 (b) City or town rural
 (c) Name of hospital or institution: none
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution all his life
 In this community all his life
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME William Orlando Rogers
 3. (b) If veteran, name war none
 3. (c) Social Security No. none

4. Sex male
 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Fanny Rogers
 6. (c) Age of husband or wife if alive 65 years
 7. Birth date of deceased Sept. 18th 1871
 (Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days
 If less than one day hr. min.

9. Birthplace Saline Co. Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name Sam Rogers
 13. Birthplace Va.

MOTHER FATHER { 14. Maiden name Henrietta Smith
 15. Birthplace Mo.

16. (a) Informant's own signature Mrs. Fanny Rogers

(b) Address Miami, Mo.

17. (a) Burial (b) Date thereof 1/20/40
 (Burial, cremation or disposal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethel Cemetery

18. (a) Signature of funeral director Bill Brothers

(b) Address Slater, Mo.

19. (a) 1-20-1940 (b) Mrs. Aubrey Haines
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 No.
 (a) State Mo. (b) County Saline
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 18th
 year 1940 hour 4 a minute M.

21. I hereby certify that I attended the deceased from Jan. 13
1940, to Jan. 18, 1940
 that I last saw him alive on Jan. 18, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris Duration
+ Myocarditis.

Due to

Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature O. W. Anderson (M. D. or other)

Address Slater Mo Date signed 1-19-40

RECEIVED
District Health Officer No. 8
District File Number 9/14/10
Date Filed

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.....

Edgar Moore

....., Registered Apprentice No. 230

working under my personal supervision.

Signed A. C. Hill

Licensed Embalmer No. 3000

P. O. Address Slater, 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 this body is not embalmed, above space should be left blank.