

BUREAU OF VITAL STATISTICS
OCT 16 1940MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

32141

Registration District No. 959

Primary Registration District No. 4-12-5504

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Hickory(b) City or town Weaubleau Rural

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2

(Specify whether

In this community

years, months or days)

3. (a) PRINT FULL NAME Nancy Clelia Rogers

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex female5. Color or race White6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Jap Rogers

6. (c) Age of husband or wife if

alive 15 years7. Birth date of deceased Nov 15 1856

(Month)

(Day)

(Year)

8. AGE:

Years 83Months 9Days 16

If less than one day

hr. min.

9. Birthplace Mo

(City, town, or county)

(State or foreign country)

10. Usual occupation Housewife11. Industry or business 112. Name Ephraim Dent13. Birthplace Mo

(City, town, or county)

(State or foreign country)

14. Maiden name Frances Halbert15. Birthplace Tenn

(City, town, or county)

(State or foreign country)

16. (a) Informant Dr Halbert(b) Address Weaubleau, Mo17. (a) burial

(Burial, cremation, or removal)

(b) Date thereof 9/3/40

(Month) (Day) (Year)

(c) Place: burial or cremation Cypresser Cem18. (a) Signature of funeral director JR Lintley(b) Address Wheatland Mo19. (a) 9/12

(Date received local registrar)

(b) Lura V. Burns

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo(b) County Hickory(c) City or town Rural - Weaubleau

(If outside city or town limits, write "RURAL")

(d) Street No. 0

(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1year 1940 hour 11 minute 00 M.21. I hereby certify that I attended the deceased from Aug 15, 194019 to Sept 1 1940that I last saw her alive on Sept 9 1940

and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure

Duration

Due to Toxemia fromintestinal obstruction 15 daysDue to 1

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?

320

While at work?

(Specify type of place)

(e) Means of injury 523. Signature H. W. R. Easton (M.D. or other) W. O.Address Weaubleau, MoDate signed 9/5/40

1222

RECEIVED

District Health Officer No. 7,

District File Number 10-40-1478

Date Filed 10-11-40

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed: JR Luckey
Licensed Embalmer No. 12989
P. O. Address Wheatland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 32141

Registration District No. 359

Primary Registration District No. 5504

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Hickory
(b) City or town Wheatland T. P.
(If outside city or town limits, use "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Nancy Celenia Rogers
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 83 Months 9 Days 16 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

20. DATE OF DEATH: Month Sept day 1
year 1970 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that I saw him _____ alive on _____ and that death occurred on the date and hour stated above.
Immediate cause of death Septicemia Duration _____

Due to Septicemia from intestinal obstruction
Due to injury from a cab wreck 1 1/2 yrs ago
Other conditions _____ (Include pregnancy within 3 months of death) 12/2/68

Major findings: Of operations no operations
Of autopsy no 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) _____ (c) Means of injury _____

23. Signature W. G. R. Easton (M. D. or other) W. G.
Address Wheatland Date signed mo

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

