

Registration District No. **1-3** Primary Registration District No. **4357** Registrar's No. _____

1. PLACE OF DEATH:
(a) County **New Madrid**
(b) City or town **Morehouse**
(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 _____ (Specify whether _____)
In this community **2 Mo., 26 days** years, months or days _____

3. (a) PRINT FULL NAME **Harry Wayne Rodgers**
(b) If veteran, name war **none**
(c) Social Security No. **none**

4. Sex **Male** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Infant**
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **8** (Month) **9** (Day) **1940** (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	2	26	hr. _____ min.

9. Birthplace **Morehouse, Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business **Infant**

12. Name **Melvin Rodgers**

13. Birthplace **Klines Island, Mo.** (City, town, or county) (State or foreign country)

14. Maiden name **Pauline Brown**

15. Birthplace **Stoddard Co., Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Melvin Rodgers**

(b) Address **Morehouse, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11 6 1940** (Month) (Day) (Year)

(c) Place: burial or cremation **Idalia, Mo.**

18. (a) Signature of funeral director *[Signature]*

(b) Address **Sikeston, Mo.**

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **New Madrid**
(c) City or town **Morehouse, Mo.** (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 **Nov** day **5** year **1940** hour **4** minute **0:00 P.M.**

21. I hereby certify that I attended the deceased from **11-1-40**, 19**40**, to **11-5-40**, 19**40**; that I last saw **her** alive on **11-5**, 19**40** and that death occurred on the **date** and hour stated above.

Immediate cause of death **Shots -Premature -Dysentery**

Due to _____

Due to _____

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? **5310**

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

23. Signature *[Signature]* (M. D. or other _____) Address **Morehouse, Mo.** Date signed **11-5-40**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

7-39
K23152

DEC 11 1940

RECEIVED

District Health Officer No. 2

District File Number 1240-178

Date Filed 12/9/40

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.....

Body not Embalmed

Registered Apprentice No.

working under my personal supervision.

Signed

Samuel Johnson

Licensed Embalmer No. 3704

P. O. Address *Westerly, RI*

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. 39328

Registration District No. 603

Primary Registration District No. 4357

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town warehouse
(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 _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County New Madrid
(c) City or town Marathon Mo
(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.

3. (a) PRINT FULL NAME

Harry Wayne Rodgers

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 2
year 1940 hour _____ minute _____ M.

3. (b) If veteran, name war _____

(c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced m
6. (c) Age of husband, or wife, if alive _____ year

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

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

Immediate cause of death _____

8. AGE: Years Months Days If less than one day
2 26 _____ hr _____ min.

Due to _____

Due to _____

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

Other conditions: (Include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings:

Of operations _____

Of autopsy _____

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) Jan 31 1941 (b) Mrs John Parish
(Date received local registrar) (Registrar's signature)

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

23. Signature J M Sarno (M. D. or other) _____

Address warehouse Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-39328