

41254

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

4647

Registration District No. 399

Primary Registration District No. 1002

## 1. PLACE OF DEATH:

(a) County Jackson 20  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution  
4201 Chestnut  
(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 yrs  
years, months or days)

8. (a) PRINT FULL NAME JAMES L. ROGERS8. (b) If veteran, name war sw 8. (c) Social Security No. sw

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Larina A. Kitchen 6. (c) Age of husband or wife if alive 22 yrs 1965  
7. Birth date of deceased NOV 22 1940  
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 13 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Durham, Mo  
(City, town, or county) (State or foreign country)10. Usual occupation Trucker 1

## 11. Industry or business

MOTHER FATHER { 12. Name Wellington Rogers 9  
13. Birthplace DK Va  
(City, town, or county) (State or foreign country)  
14. Maiden name Annagarty  
15. Birthplace DK Va  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John L. Rogers(b) Address 4201 Chestnut17. (a) Bur. (b) Date thereof Dec 7 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Memorial Park Cemetery18. (a) Signature of funeral director Rowell(b) Address Co. Lincoln Mo19. (a) 12-6-40 (b) M.M. Crowe  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4201 Chestnut St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 5  
year 1940 hour 8 minute 05 M.21. I hereby certify that I attended the deceased from  
Aug 10, 1940, to Dec 5, 1940  
that I last saw him alive on Dec 5, 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral Hemorrhage Duration 1 hrDue to Chron Intertidal Nephritis

Due to \_\_\_\_\_

Other conditions 131  
(Include pregnancy within 8 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?  
no

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

23. Signature J. Donaldson (M. D. or other) MDAddress 2714 Broadway Date signed 12/5/40

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

Rev. 6-17-39  
1 x10311

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.

Willard

4335

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**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.....

*Willard*  
.....  
Licensed Embalmer No. *3183*

P. O. Address..... *Columbia 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.**