S. No. 2
9-4-41
5-17-39
X29488

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

8026

State File No.

FILED MAR 8 1943

Registration District No. 379

Primary Registration District No. 6287

Registrar's No. 6

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

1. PLACE OF DEATH:

(a) County Wright

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

(c) Name of hospital or institution: Pleasant Valley Inn
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 26 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright 114

(c) City or town Cedar Gap 0
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Vivian Louise Rogers

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F.

5. Color or race W.

6. (a) Single, widowed, married, divorced —

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Dec (Month) 20 (Day) 1942 (Year)

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

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

10. Usual occupation Infant

11. Industry or business —

FATHER
12. Name Edgar Rogers
13. Birthplace Unknown (City, town, or county) Ark. (State or foreign country)

MOTHER
14. Maiden name Rozie Gold
15. Birthplace Stone (City, town, or county) Mo (State or foreign country)

16. (a) Informant John S. Marlen
(b) Address Cedar Gap Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan (Month) 17 (Day) 1943 (Year)
(c) Place: burial or cremation Cedar Gap Cem

18. (a) Signature of funeral director Kelley-Terrell
(b) Address Seymour Mo

19. (a) Jan 20 1943 (Date received local registrar) (b) S. L. Hensley (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 16
year 1943 hour 5 minute a.m.

21. I hereby certify that I attended the deceased from 1-15 1943, to 1-16 1943
that I last saw her alive on 1-15 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia | Duration 3 days

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

23. Signature J. F. Fuson (M. D. or other)
Address Mansfield Mo Date signed 1-17-43

1261

(Licensed Embalmer's Statement on Reverse Side)

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 K. K. Kellen

Licensed Embalmer No. 3334

P. O. Address Seymour, M

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

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

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8026

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

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

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Cedar Gap
(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 26 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright

(c) City or town Cedar Gap
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Vivian L. Rogers

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Dec - 20 - 1942
(Month) (Day) (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16
year 1943 hour ..... minute ..... M.

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.

	Duration
Immediate cause of death Bronchial Pneumonia	
Due to	
Due to	
Other conditions None (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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature J. A. Fuson (M. D. ~~or other~~)
Address Mansfield Mo Date signed 4-1-43

SUPPLEMENTARY

107

4-1-43