

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 31 1944

4552

Registrar's No. 57

Registration District No. 378

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Mtn. Grove
(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. 1
(Specify whether

In this community No
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright 114

(c) City or town Mtn. Grove 1
(If outside city or town limits, write "RURAL") 0

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

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

3. (a) PRINT FULL NAME Thomas M. Rogers

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19
year 1944 hour 6:45 minute A.M.

21. I hereby certify that I attended the deceased from 3/10/43
....., 19....., to 1/18, 19.....

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Nellie F. Rogers

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased July 3, 1876
(Month) (Day) (Year)

that I last saw him alive on 1/18, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of colon + rectum Duration 2 yrs.

8. AGE: Years Months Days If less than one day

67 6 16 hr. min.

Due to Carcinoma of colon + rectum

Due to

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Minister

Major findings: Of operations none

Of autopsy none

MOTHER FATHER

11. Industry or business

12. Name James Rogers

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

14. Maiden name James Story

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Nellie Rogers

(b) Address Mtn. Grove, Mo.

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?

17. (a) BURIAL (b) Date thereof 1/22/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dutch Chapel Cemetery

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

18. (a) Signature of funeral director Russell Barber

(b) Address Mtn. Grove

19. (a) 1-26-44 (b) H. M. Lower
(Date received local registrar) (Registrar's signature)

23. Signature W. R. Gans (M. D. or other) DO

Address Mountain Grove, Mo. Date signed 1/22/44

RECEIVED

District Health Officer No. 6;

District File Number 144-119

Date Filed JAN 27 1944

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

Russell W. Barber
Licensed Embalmer No. 3828
P. O. Address Mt. Airy, N.C.

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, fact should be so stated above.

FILED FEB

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 378

Primary Registration District No. 4552

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Wright City, Mo.
(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 _____ years, months or days

3. (a) PRINT FULL NAME Thomas M. Rogers

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ year

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

8. AGE: Years 67 Months 6 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-26-44 (b) H. M. Louder

(Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 29 Year 1944 hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

4834