

FILED SEP 22 1948
Registration District No. 2478

Primary Registration District No. 5741

Registrar's No. 43

1. PLACE OF DEATH:

(a) County: Marion

(b) City or town: Buckles Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 Rt # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: 4 1/2 years
In hospital or institution. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Marion

(c) City or town: Rt # 3, Buckles Mo.
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? no (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: JAMES EMIT ROGERS

3. (b) If veteran, name war: _____

3. (c) Social Security No.: _____

4. Sex: male

5. Color or race: white

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

6. (b) Name of husband or wife: Elaine Rogers

6. (c) Age of husband or wife if alive: 48 years

7. Birth date of deceased: Sept 21, 1880
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|-----------|-----------|----------------------|
| <u>67</u> | <u>11</u> | <u>17</u> |hr.min. |

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

10. Usual occupation: Farmer & Section Foreman

11. Industry or business: Farming & Santa Fe R.R.

12. Name: Joe Rogers

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

14. Maiden name: Martha Day

15. Birthplace: Marion Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant: Elmer Rogers

(b) Address: Buckles Mo.

17. (a) Burial (b) Date thereof: Sept 10, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Cash Cem

18. (a) Signature of funeral director: James Funeral Service

(b) Address: Buckles Mo.

19. (a) Sept 10, 1948 (b) Josephine King
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept day: 8 year: 1948 hour: 1 minute: 55 P.M.

21. I hereby certify that I attended the deceased from Sept 7, 1948 to Sept 7, 1948 that I last saw him alive on Sept 7, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia

Due to: _____

Due to: _____

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

Major findings: _____

Of operations: _____

Of autopsy: 1

PHYSICIAN

Underline the cause of which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? _____ Means of injury: _____

23. Signature: Howard D. Miller (M. D.)
Address: Marion, Mo. Date signed: 9-10-48

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

MOTHER FATHER

OCT 6 1948

RECEIVED
District Health Officer No. 10
District File Number 948-165
Date Filed SEP 21 1948

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..... *E. A. Larson*

Licensed Embalmer No..... 4037

P. O. Address..... *Bucklin, 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, fact should be so stated above.

Registration District No. 198

Primary Registration District No. 5741

1. PLACE OF DEATH:

(a) County Macon Rural
(b) City or town Macon 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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

James E. Rogge

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 M

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

7. Birth date of deceased Sept 21 (Month) (Day) (Year)

8. AGE: Years 67 Months _____ Days _____ (If less than one day) _____ hr. _____ min.

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

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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 _____ Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

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

Immediate cause of death _____

Due to fractured femoral neck 2 day

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? _____

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

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S-30360