

S. No. 300
M-10-47
ev. 5-17-39
I 3906

FILED NOV 9 1948
Registration District No. _____

Primary Registration District No. **3012**

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

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution: Excelsior Springs Hospital
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 5 hrs.
(Specify whether _____)

In this community 1 week.
years, months or days)

3. (a) PRINT FULL NAME MYRON C. ROGERS

3. (b) If veteran, name war No.

3. (c) Social Security No. NO.

4. Sex M | 5. Color or race W

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

6. (b) Name of husband or wife Anna R. Rogers

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased: Dec 15 1877
(Month) (Day) (Year)

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

70 | 10 | 4 | hr. min.

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

10. Usual occupation Attorney

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Anna C. Rogers

(b) Address 307 N. Cherry St. Morrison Ill.

17. (a) Removal (b) Date thereof Oct 19 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prophetstown Ill.

18. (a) Signature of funeral director Virgil Hope

(b) Address Excelsior Springs Mo

19. (a) 10/19/48 (b) Caroline Hollings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Whiteside

(c) City or town Morrison Ill
(If outside city or town limits, write "RURAL")

(d) Street No. 307 N. Cherry St. 2
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1948 hour 12:25 minute P M.

21. I hereby certify that I attended the deceased from 10-19-48
5:00 AM 19to 10-19 1948
that I last saw him alive on 10-19-48 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage Duration 1 hr.

Due to cerebral hemorrhage 6 hrs.

Due to hypertension and cerebral arterial sclerosis 10 yrs.

Other conditions hypertrophied prostate 5 yrs.
(include pregnancy within 6 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? _____

(Specify type of place)

While at work? _____ (e) Means of injury fall

23. Signature David Musgrave M.D. (M. D. or other)

Address Excelsior Springs, Mo Date signed 10-19-48

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

11-8-78

OCT 18 1949

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 _____

Chas. Virgil Hope

Licensed Embalmer No. *3950*

P. O. Address *Excelsior Springs, 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.