FILED AUG 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25820
STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 195

1. PLACE OF DEATH
a. COUNTY ST. CHARLES
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. CHARLES — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL ~~OR INSTITUTION~~ (If NOT in hospital, give location) ST. JOSEPH'S — Length of stay in 1b 7 HRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri — b. COUNTY Lincoln
c. CITY OR TOWN ELSBERRY 057 — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 707 N. Fourth — Reside on Farm Yes X No ☐

3. NAME OF DECEASED (Type or print) First JOSEPH Middle WESLEY Last ROGERS
4. DATE OF DEATH Month JULY Day 30 Year 1957
5. SEX Male
6. COLOR OR RACE WHITE
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH JAN. 9, 1876
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmed
10b. KIND OF BUSINESS OR INDUSTRY tenant farm
11. BIRTHPLACE (City and state or country) Rogersville, Tenn.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas J. Rogers
14. MOTHER'S MAIDEN NAME SARAH LAWSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address RAYMOND ROGERS - ST. CHARLES, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 8 Hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Thrombosis — 3
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 0

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 30 - 1957 to July 30, 1957 last saw her/him alive on July 30, 57
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. M. [illegible] M.D.
22b. ADDRESS St. Charles Mo
22c. DATE SIGNED July 31-1957

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE AUG. 1957
23c. NAME OF CEMETERY ~~OR CREMATORY~~ CITY
23d. LOCATION (City, town, or county) (State) ELSBERRY, Mo.

24. FUNERAL DIRECTOR [illegible] ADDRESS Elsberry, Mo.
25. DATE RECD. BY LOCAL REG. AUG 1-57
26. REGISTRAR'S SIGNATURE Marcella Wilson

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 401

P. O. Address Elsberry

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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