

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017533
STATE FILE NUMBER

FILED MAY 19 1958 Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 40

S. 300
7-1-57
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1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Carrollton 0176</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Calais Hosp.</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>403 N. Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>NETTIE BIRD ROGERS</u>			4. DATE OF DEATH Month Day Year <u>May 12 1958</u>		
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26, 1869</u>		9. AGE (In years last birthday) <u>89</u> UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Marion Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>William Bird</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jane Glascock</u>		14. NAME OF HUSBAND OR WIFE <u>James A. Rogers Sr.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Walter M. Guirey</u> Address <u>Carrollton Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause, no ligatures, etc.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured, comminuted Head, Neck Trochanter. Shaft of Rt femur.</u>			INTERVAL BETWEEN DEATH AND DEATH <u>4 Days</u>
DUE TO (b) <u>Fall in Home 5 AM, (Favored 9 AM) SHOCK.</u>			
DUE TO (c) <u>Senility.</u>			9040 21
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephritis, Arteriosclerosis, Myocardial Infarction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Fell in Home. Not found for 3 1/2 hours.</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
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 <u>May 8 1958</u> to <u>May 12 1958</u> and last saw her alive on <u>May 21 1958</u> Death occurred at <u>2:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Cecep Calcedo</u>	22b. ADDRESS <u>Carrollton Mo.</u>	22c. DATE SIGNED <u>5-15-58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Carrollton, Mo.</u>
24. FUNERAL DIRECTOR <u>Stanley Gibson</u> ADDRESS <u>Carrollton Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5/13/58</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Herbert Calvert</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

45-C

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, Student Embalmer No. working under my personal supervision.

Student

Signature of Student Embalmer

Signed *Ben W. Gibson*

Licensed Embalmer No. *2961*

P. O. Address *Carrollton*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.