MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Newton
Township: Franklin
or Village: Fairview
or City ______ (NO. ______ St.; ______ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 608
Primary Registration District No. 4362
File No. 39 30870
Registered No. ______

FULL NAME Osker Lee Rodgers

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	W	

DATE OF BIRTH: May 26 (Month) (Day), 1908 (Year)

AGE: 11 yrs. 4 mos. 12 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Child at home
(b) General nature of industry, business, or establishment in which employed (or employer): ______

BIRTHPLACE (City or town, State or foreign country): Newton Co Mo

PARENTS
NAME OF FATHER: John Rodgers
BIRTHPLACE OF FATHER (City or town, State or foreign country): Barry Co Mo
MAIDEN NAME OF MOTHER: Ellen Byrd
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Maries Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pearl Rodgers
(ADDRESS) Pearl Rodgers Mo

Filed Oct 11th, 1919 L N Parnell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 2nd (Month) (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 12, 1919, to Oct 2nd, 1919, that I last saw him alive on Oct 2, 1919, and that death occurred, on the date stated above, at 1:20 p.m.

The CAUSE OF DEATH* was as follows:
Septicemia from Periostitis of Left Femur, 1558
(Duration) ___ yrs. ___ mos. 20 ds.

Contributory (SECONDARY) ______
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) S A Russell M. D.
Oct 3, 1919 (Address) Fairview Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? ______
Former or usual residence ______

PLACE OF BURIAL OR REMOVAL: Dice Cem. Newton Co Mo
DATE OF BURIAL: Oct 3, 1919
UNDERTAKER: J H White & son
ADDRESS: Fairview Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____, 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____ 191____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.