

No. 2  
4-13-40  
5-17-39  
X23189

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
JAN 10 1941 318

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

42501

State File No. \_\_\_\_\_  
Registrar's No. 970

Registration District No. \_\_\_\_\_ Primary Registration District No. 2001

39  
3  
6

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

1. PLACE OF DEATH:  
(a) County GREENE  
(b) City or town Springfield  
(c) Name of hospital or institution: 916 Garfield  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Greene  
(c) City or town Springfield  
(d) Street No. 916 Garfield  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME SAMANTHA CAROLINE FITZPATRICK  
(b) If veteran, name war no (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 3 year 1940 hour 12 minute 30 P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Dec 1864 years

21. I hereby certify that I attended the deceased from 12-3-1940 to 12-3-1940 and that death occurred on the date and hour stated above.

8. AGE: Years 80 Months 4 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Senility Duration 1 year

9. Birthplace Unknown Unknown  
(City, town, & county) (State or foreign country)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation House Wife  
11. Industry or business In home

PHYSICIAN \_\_\_\_\_  
Underline (the cause to which death should be charged statistically).

MOTHER FATHER  
12. Name Unknown  
13. Birthplace Unknown Unknown  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant Mrs. Thelma Jensen  
(b) Address Springfield Mo. R# 13  
(c) Place: burial or cremation Green Lawn

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director W. E. Handley  
(b) Address Springfield, Mo.  
19. (a) 12-4-40 (b) W. E. Handley M.D.  
(Date received local registrar) (Registrar's signature)

Signature P. E. Jellen (M. D. or other) \_\_\_\_\_  
Address Springfield Mo. Date signed \_\_\_\_\_

**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.....

*Roy A. Lawin*

Licensed Embalmer No.....

*1763*

P. O. Address.....

*Springfield 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.**

*X*