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

Registration District No. 128
Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County. GREENE

(b) City or town. SPRINGFIELD

(c) Name of hospital or institution: 2043 N. KELLETT /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 44 YRS. (Specify whether years, months or days)

In this community.

3. (a) PRINT FULL NAME SARAH CAROLINE STEVER THOMAS

3. (b) If veteran, name war. NONE

3. (c) Social Security No. NONE

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 7-4 1860

7. Birth date of deceased. May 7-4 1860

8. AGE: Years 82 Months 8 Days 7

If less than one day hr. min.

9. Birthplace. Unknown MO. S

(City, town, or county) (State or foreign country)

10. Usual occupation. HOUSE WIFE

11. Industry or business. IN HOME

MOTHER FATHER

12. Name. DAVID T. ROGERS

13. Birthplace. Unknown TENN. /

14. Maiden name. DELELLAH C. FLETCHER.

15. Birthplace. Unknown TENN. /

16. (a) Informant. Mrs. Sta Potect

(b) Address. Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof. Jan 17-1943

(c) Place: burial or cremation. Green Lawn

18. (a) Signature of funeral director. J. W. Klingner

(b) Address. Springfield, Mo.

19. (a) 1-16-43 (Date received local registrar)

(b) S. W. S. Handley (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. MO. (b) County. Greene

(c) City or town. Springfield

(d) Street No. 2043 N. KELLETT

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

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 14th year 1943 hour 7 minute 05 P. M.

21. I hereby certify that I attended the deceased from 1/14/43 to 1/14/43

that I last saw h. or alive on 6/11/42 and that death occurred on the date and hour stated above.

Immediate cause of death. Probably acute subarachnoid hemorrhage. Heart was dead when I arrived

Due to.

Due to.

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations. 954

Of autopsy.

PHYSICIAN

Underline the cause to which death should be charged etiologically.

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?

While at work? (Specify type of place) (e) Means of injury.

23. Signature. J. A. E. Deeder (M. D. or other)

Address. Springfield, Mo. Date signed. 1/19/43

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.....

Licensed Embalmer No.....

P. O. Address.....

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