

FILED DEC 12 1947
Registration District No. **2000**

Primary Registration District No. **2000**

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1421 W. Catalpa
(If not in hospital or institution, write street number or location)
(d) Length of stay: **14 Months**
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Margaret Tompkins**

3. (b) If veteran No. name war..... 3. (c) Social Security No. **No.**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Widow**
6. (b) Name of husband or wife **Wid. of Perry Tompkins** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **June 26 1866**
(Month) (Day) (Year)

8. AGE: Years **81** Months **5** Days **3** If less than one day hr. **0** min.

9. Birthplace **Nodaway Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **In home**

12. Name **John F. Partridge**

13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Lucinda Mapes**
15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Fred Tompkins**
(b) Address **1421 W. Catalpa**

17. (a) **Removal** (b) Date thereof **11-30-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Maryville, MO**

18. (a) Signature of funeral director **J. W. Klingner**
(b) Address **Springfield, Missouri**

19. (a) **11-29-47** (b) **W.E. Standley M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene** **39**
(c) City or town **Springfield,** **2**
(If outside city or town limits, write "RURAL") **6**
(d) Street No. **1421 W. Catalpa**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country..... **D**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **29**
year **1947** hour **9** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **Nov 26**, 19**47**, to **Nov. 29**, 19**47**
that I last saw him **Nov 28** alive on **Nov 28**, 19**47**
and that death occurred on the date and hour stated above. **Duration**

Immediate cause of death **Cardiac failure**
Due to **angina pectoris or cerebral thrombosis**
Due to **Arteriosclerosis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations..... **MI**
Of autopsy.....

PHYSICIAN

Underline the cause of which death should be charged statistically.

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..... **0**
23. Signature **E. J. Hanan** (M. D. or other) **M.D.**
Address **1421 W. Catalpa** Date signed **11-29-47**

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

MOTHER FATHER

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..... *Ogle Stone Jr.*.....

Licensed Embalmer No..... *4176*.....

P. O. Address..... *Springfield*.....

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.