

No. 300  
-10-47  
-17-39  
PI 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

R Fitch  
State File No. 25995  
Registrar's No. 694-A

FILED SEP 7 1948

Registration District No. 128

Primary Registration District No. 2000

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

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:  
2053 N. Rogers  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether  
In this community 60 years years, months or days)

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")

(d) Street No. 2053 N. Rogers 6  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Catherine B. Roberts

3. (b) If veteran, name war no 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joseph E. Roberts 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased November 27 1884  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>8</u>	<u>24</u>	hr. _____ min.

9. Birthplace Standard Vermont  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business none

12. Name John J. Smith

13. Birthplace Unknown Scotland  
(City, town, or county) (State or foreign country)

14. Maiden name Marie A. Smith

15. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph E. Roberts

(b) Address 2053 N. Rogers

17. (a) Burial (b) Date thereof 8-24-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cemetery

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Missouri

19. (a) 8-30-48 (b) W. Handley MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21st  
year 1948 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 1948 to Aug 21st 1948  
that I last saw h. alive on Aug 20 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Paralysis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Duration 1 yr.

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

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

PHYSICIAN  
Underline the cause to 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? Yes (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature W. Handley MD (M. D. or other) MD  
Address Springfield, Mo Date signed 8-24-48

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**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 James B. Gaughen  
Licensed Embalmer No. 45604  
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.**