

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

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7-30
K38671

FILED OCT 9 1948

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 853

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:
St. John Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 Month
(Specify whether _____)

In this community 17 Years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield
(If outside city or town limits, write "RURAL") 2

(d) Street No. 1011 S. Delaware
(If rural, give location) 5

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

If yes, name country _____

3. (a) PRINT FULL NAME Lizzie Rector

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6
year 1948 hour 1 minute a. M.

21. I hereby certify that I attended the deceased from 8/18/48, 19 to 10/6/48, 19 ;
that I last saw her alive on Oct. 5, 1948,
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Rev. Wm. G. Rector

6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased Feb. 28 1870
(Month) (Day) (Year)

Immediate cause of death _____

Due to Carcinoma of Head & Neck & Pancreas with Generalized abdominal metastasis

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>7</u>	<u>8</u>	hr. min.

9. Birthplace Terre Haute Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER {

12. Name William A. Sterling

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

14. Maiden name Ann Jane Wood

15. Birthplace Rhode Island
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W.L. Christopher

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 10/9/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lee's Summit, Mo.

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

(b) Address Springfield, Mo.

19. (a) 10-8-48 (b) W.L. Handley
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) none

(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) (d) Means of injury 0

23. Signature William J. Paul (M.D. or other) ✓

Address 809 Professional Bldg. Springfield, Missouri Date signed 10/6/48

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.....

Walter E. Hamiller

Licensed Embalmer No..... 3808

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.