

FILED FEB 13 1940

State File No. _____

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 83

1. PLACE OF DEATH:

(a) County Springfield
(b) City or town _____
(c) Name of hospital or institution: 2205 N. Campbell
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days 2 1/2

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield
(d) Street No. 2205 N. Campbell
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME SARAH MARGARET BECKERDITE

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

7. (b) Name of husband or wife Lorenzo Bryant Beckerdite 8. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 6 - 1851
(Month) (Day) (Year)

8. AGE: Years 88 Months 9 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business In home

12. Name Hiram Kibbe

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

14. Maiden name Unknown

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

16. (a) Informant Gles Amstutz
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Jan 28 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Chrys. Cemetery
18. (e) Signature of funeral director L. M. ...
(b) Address Springfield, Mo. 290
19. (a) 1/27/40 (b) Chas. A. Kemp
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20th (26)
year 1940 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from 1-26-40
_____ 19____, to 1-26-40 19____;
that I last saw her alive on 1-26-40 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Burns of Face, body, arms & hands
Senility Duration 8 hrs.

Due to _____
Due to _____

Other conditions 181
(Include pregnancy within 3 months of death) 110

Major findings: 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) Burns accident
(b) Date of occurrence housedid not burn. 1-26-40
(c) Where did injury occur? 2205 N. Campbell, Springfield, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about (home) on farm, in industrial place, in public place?
clothing caught on fire from stove
While at work? _____ (e) Means of injury _____

23. Signature C. R. ... (M. D. or other) _____
Address Springfield, Mo. Date signed 1-26-40

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

837 038

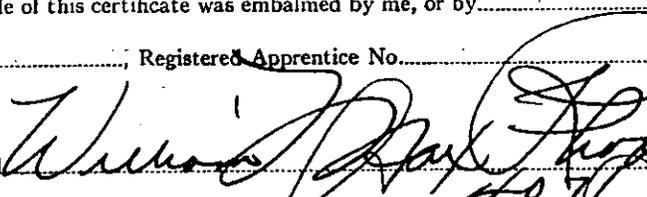
STATEMENT BY LICENSED EMBALMER

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, above space should be left blank.