

JUN 13 1940
Registration District No. 318

Primary Registration District No. 2001

444 "A"

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: 749 S. Pickwick 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Delilah Sams 590
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Leri E. Sams 6. (c) Age of husband or wife if alive (Dec) years
7. Birth date of deceased January 10, 1898
(Month) (Day) (Year)

8. AGE: Years 1 Months 92 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business In Home

MOTHER FATHER
12. Name James Watts
13. Birthplace Jeppon (City, town, or county) (State or foreign country)
14. Maiden name Delilah Sams
15. Birthplace Unknown Jeppon (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Albert J. Sams
(b) Address 749 S. Pickwick, City
17. (a) Burial (b) Date thereof 5-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director Alma Schuyler
(b) Address Springfield Mo
19. (a) 5-17-40 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 0 749 Pickwick
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16
year 1940 hour 3 minute 45 P. M.
21. I hereby certify that I attended the deceased from May 13, 1940, to May 16, 1940

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Heart disease
Arteriosclerosis
Hypertension
Stroke

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) None

Major findings: Of operations _____
Of autopsy _____

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 Henry F. Krabbe MD (If Doctor) _____
Address 4507 1/2 Court Date signed 5/21/40

WHITE PRINT USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X10811

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.