

No. 2  
4-13-40  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

42557

State File No. \_\_\_\_\_

318

Primary Registration District No. 2001

Registrar's No. 1033

Registration District No. \_\_\_\_\_

39  
3  
6  
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:  
513 E. Monroe  
(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 2

3. (a) PRINT FULL NAME Sarah Rosa Spickard

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Edward A. Spickard

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

7. Birth date of deceased December 11 1868  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

72	0	15	hr. min.
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9. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business In Home

12. Name Unknown (Joiner)

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

14. Maiden name Unknown

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

16. (a) Informant Berne Spickard

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof 12/28/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 12-28-40 (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. 513 E. Monroe  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26  
year 1940 hour 2 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from 9-22 1940 to 12/26 1940  
that I last saw her alive on 12/25 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 28

Due to Hyper-tension

Due to Arterio Sclerosis

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

Major findings: Of operations no

Of autopsy no

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) no

(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? Accident  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. E. Handley MD (M. D. or other) \_\_\_\_\_

Address Springfield Date signed 12/29/40

**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, fact should be so stated above.**

X