

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Marion
Township Mason
City Hannibal (No. 1904)

Registration District No. 547
Primary Registration District No. 3039
Chestnut St.

File No. 1828
Registered No. 41
St. _____ Ward _____

2. FULL NAME Mary Frances Sampson

(a) Residence. No. 1904 Chestnut St., _____ Ward _____

(Usual place of abode) _____ (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
XXXXXXXXXXXXXXXXXXXX

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 22 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
0 8 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Hannibal
(STATE OR COUNTRY) Marion Co. Mo.

10. NAME OF FATHER Wm. E. Sampson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Calaway, Co. Mo.

12. MAIDEN NAME OF MOTHER Ruby Kemp

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Calaway, Co. Mo.

14. INFORMANT Mr. Wm. E. Sampson
(Address) 1904 Chestnut St. Hannibal

15. FILED 2/27 1927 W. E. Steele
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 28 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1927 to Jan 28 1927 that I last saw her alive on Jan 28 1927 and that death occurred, on the date stated above, at 10:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Peritonitis
1195 113 B
129 (duration) yrs. mos. ds. 3
CONTRIBUTORY (SECONDARY) Calitis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. C. Chilton, M. D.
, 19 1927 (Address) Hannibal

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Olivet Cem. DATE OF BURIAL 1/30 1927

20. UNDERTAKER Wm. M. Smith ADDRESS Hannibal

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.

RECORD

J. C. Chilton

1927

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