

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

Do not use this space.

23997

1. PLACE OF DEATH

County Jackson Registration District No. 1002
 Township 10th Primary Registration District No. _____
 City Kansas City, Mo (No. Willow's Hope 2929) Main St. 3124 Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

Ward Sampson
 (a) Residence. No. Willow's Hope 2929 Main 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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Babe

5A. (If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of _____)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12 - 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Baby
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City, Mo.
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Laura Sampson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Missouri

14. INFORMANT Glady's K. Miller
 (Address) 2929 Main St. KC Mo

15. FILED 7/21-28 M. M. Crowe
 REGISTAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) July 17 1928

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1928, to July 17, 1928 that I last saw him alive on July 17, 1928, and that death occurred, on the date stated above, at 2:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Congenital Syphilis
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 38
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Histopneumone
 (Signed) H. Miller M. P.
 7/17, 1928 (Address) 214 Medical Art Bldg

*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 Maple Hill DATE OF BURIAL July 21 1928

20. UNDERTAKER Keylor Bros 1800 Linnwood ADDRESS _____

WRITE PLAINLY, WITH OUPSIDING INFORMATION

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.

