

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

Do not use this space.

22861

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Waynesville Primary Registration District No. 1092
 City Waynesville No. 342 M. White
 St. _____ Ward _____

2. FULL NAME

Edward M. Sampson
 (a) Residence. No. 342 M. White St. 10 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 19 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna D Sampson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 13-1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 11 27

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

9. BIRTHPLACE (CITY OR TOWN) Waynesville
 (STATE OR COUNTRY) Ill

10. NAME OF FATHER Wm M Sampson

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

12. MAIDEN NAME OF MOTHER Mary Crane

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

14. INFORMANT Mrs Anna Sampson
 (Address) 342 M white

15. FILED 7/11 1930 Dr. M. Crane REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 10 1930

17. I HEREBY CERTIFY, That I attended deceased from 6/9 1929 to 7/10 1930
 that I last saw h. _____ alive on 7-10 1930 and that death occurred, on the date stated above, at 5:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of liver
462

44 B (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) _____ (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) A. Williams M. D.
7/11 1930 (Address) 442 E. John St. Waynesville, Mo.

*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. Washington DATE OF BURIAL July 12 1930

20. UNDERTAKER Miss. E. & Forster ADDRESS W. E. Mo.

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.

5400 St John