

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

Do not use this space.

2128

1. PLACE OF DEATH

County Mississippi Registration District No. 566
 Township Wagon Wheel Primary Registration District No. 3030
 City Rolla (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 3

2. FULL NAME

Elizabeth Sampson
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Carry the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Near 1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
Near 81

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work At home 131 10 1/2
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Obion County Tennessee
 (STATE OR COUNTRY)

10. NAME OF FATHER William Tate

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

12. MAIDEN NAME OF MOTHER Sofa Kelly

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Obion County Tennessee
 (STATE OR COUNTRY)

14. INFORMANT J. G. Laird
 (Address) Charleston Mo.

15. FILED Jan 4 - 30 Frank S. Vernon
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/4 8:30 A.M. 1930

17. Did not have a physician
 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senile debility and chronic nephritis she died in bed before getting up in the morning (duration) yrs. mos. ds.
 CONTRIBUTORY Red eye (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? No

WHAT TEST CONFIRMED DIAGNOSIS Family History
 (Signed) Frank S. Vernon, M. D.
 , 19 (Address) Charleston 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 Dale Grove DATE OF BURIAL 1/5 1930

20. UNDERTAKER Laird Und. Co. ADDRESS Charleston 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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 FEB 20 1931

