MAY 23 [redacted]

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

Do not use this space.

File No. 4683

Registered No. 205

1. PLACE OF DEATH

County Buchanan — Registration District No. 85

Township — Primary Registration District No. 1001

City St. Joseph, Mo. (No. Missouri Methodist Hos. St. Ward)

2. FULL NAME Infant Sampson

(a) Residence. No. 113 North 17th 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) February 23, 1931

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Joseph
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Chris Sampson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) De Kalb
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Elizabeth Wilson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sweetwater
(STATE OR COUNTRY) Wyoming

14. INFORMANT Chris Sampson,
(Address) St. Joseph Mo.

15. FILED 2-24-31, 19 John R. Bender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 23, 1931

17. 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 10 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature birth
6 mo gestation.

159 (duration) ....yrs....mos....ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ....yrs....mos....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) P. R. McGill, M. D.

2/24, 1930 (Address) 322 Hoffstein Bldg St. Joseph 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	DATE OF BURIAL
Mt. Auburn	Feb. 24, 1931
20. UNDERTAKER	**ADDRESS**
Fleeman Funeral Home	1946 Calhoun

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.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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Township: — Primary Registration District No.: 1001 — Registered No.: 205

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(Usual place of abode)

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: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

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

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

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

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(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT
(Address)

15. FILED 4-10, 1931 John R. Bender, Registrar

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..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

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IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
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(Signed) ....., M. D
, 19 (Address)

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20. UNDERTAKER — ADDRESS

SUPPLEMENTARY 157

S-4683