

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

Do not use this space.

18087

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Raw Primary Registration District No. 1082  
 City J. C. Mo. (No. 5404 Virginia) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 2228  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Samantha Esthel Brooks  
 (a) Residence. No. 5404 Virginia St. 15 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 <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Hampsey H. Brooks</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug - 25 - 1850</u>					
7. AGE	YEARS	MONTHS	DATE	If LESS than 1 day, _____ hrs. or _____ min.	
	<u>80</u>	<u>8</u>	<u>21</u>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>at home</u>					
(b) General nature of industry, business, or establishment in which employed (or employer)					
(c) Name of employer					

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
Indiana

PARENTS	10. NAME OF FATHER <u>W. J. George</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Indiana</u>
	12. MAIDEN NAME OF MOTHER <u>Jane E. Spain</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record</u>

14. INFORMANT H. G. Gusting  
 (Address) 5404 Virginia

15. FILED May 17 1931 M. M. Corwin  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May - 16 - 1931

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1931, to May 16, 1931 that I last saw him alive on May 15, 1931, and that death occurred, on the date stated above, at 10:30 AM, m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Colitis  
Exhaustion  
 (duration) yrs. 2 mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Exhaustion  
 (duration) yrs. \_\_\_\_\_ mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH California 1925

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical history etc  
 (Signed) Joseph H. Myers M. D.  
May 16 1931 (Address) 925 E. 85

\*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 <u>Cremation - Elmwood</u>	DATE OF BURIAL <u>5-18-31</u>
20. UNDERTAKER <u>Mrs. C. L. Foster</u>	ADDRESS <u>K. C. Mo.</u>

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

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.

5 E 54 Tenn. Hi - 1830

2:30 -