

REC'D DEC 12 1938

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

 37269
 Do not use this space.

1. PLACE OF DEATH

 (a) County 1 Registration District No. **791**
 (b) Township 2 Primary Registration District No. **1003**
 (c) City St. Louis, Mo. (d) Street No. BARNES HOSPITAL St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
Registered No. **9596**

2. PRINT FULL NAME

 (a) Residence, No. 5915 Agnes Samson
1617 S. Glenwood St. **SP** Springfield, Illinois
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX **Female** 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 **John Samson**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 20/1889**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 4 13

 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) **Sept. 1938** 11. Total time (years) spent in this occupation **15 yrs.**

 12. BIRTHPLACE (CITY OR TOWN) **Unknown**
 (STATE OR COUNTRY) **Scotland** **4**
13. NAME **Archibald Scott**
 14. BIRTHPLACE (CITY OR TOWN) **Scotland**
 (STATE OR COUNTRY) **4**
15. MAIDEN NAME **Agnes Brown**
 16. BIRTHPLACE (CITY OR TOWN) **Scotland**
 (STATE OR COUNTRY) **4**

 17. INFORMANT **John Samson**
 (ADDRESS) **Springfield, Illinois**

 18. BURIAL, CREMATION, OR REMOVAL PLACE **Springfield, Ill.** DATE **Nov. 6/1938**

 19. FUNERAL DIRECTOR (NAME) **Albert H. Hoppe, Inc.**
 (ADDRESS) **4700 Washington, Blvd.**

 20. **NOV 4 1938** 19 **38**
J. B. Bredbeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11-3-38** 19
 22. I HEREBY CERTIFY, That I attended deceased from **10-24-38**, 19, to **11-3-38**, 19

 I last saw h. e. f. alive on **11-3-38**, 19. Death is said to have occurred on the date stated above, at **1:35** p. m.

The principal cause of death and related causes of importance were as follows:

Brain tumor, Malignant? (Date of onset)

 Other contributory causes of importance: **Bronchopneumonia, left** **11-1-38**
Name of operation **Cranotomy** Date of **10-27-38**What test confirmed diagnosis? **Operation** Was there an autopsy? **Yes**
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19

 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

 Manner of injury
 Nature of injury

 24. Was disease or injury in any way related to occupation of deceased? **No**
 If so, specify

 (Signed) **Emmett B. Drescher** M. D.
 (Address) **BARNES HOSPITAL**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No., working under my personal supervision.

Signed

Albert J. Hays

Licensed Embalmer No. 2971

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.