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13-40
7-39
K23159
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Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution: Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Days (Specify whether
In this community 5 Days years, months or days)

3. (a) PRINT FULL NAME BETTY B. SAMPSON
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charles Sampson 6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased May 11 1890
(Month) (Day) (Year)

8. AGE: Years 50, Months 6, Days 16 If less than one day
hr. min.

9. Birthplace DeKalb Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name C. J. Roberts

13. Birthplace Unknown Kent.
(City, town, or county) (State or foreign country)

14. Maiden name Betty Gardner

15. Birthplace DeKalb Mo.
(City, town, or county) (State or foreign country)

16. (e) Informant Mrs. Ora Sampson

(b) Address 1120 Main St. Joseph, Mo.

17. (a) Removal (b) Date thereof 11-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DeKalb, Mo.

18. (e) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) 11-26-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Buchanan
(c) City or town DeKalb, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 27th.
year 1940 hour 11 minute 45 P. M.

21. I hereby certify that I attended the deceased from November 23,
1940, 19 , to November 27, 1940
that I last saw her alive on November 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac
dilatation Duration 2 days

Due to _____

Due to Shock

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Carcinoma of Uterus
11-24-40
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
85

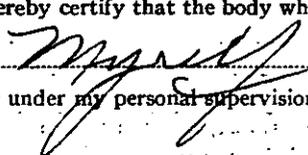
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) D. O.
Address 833 Farnon St. JOSEPH Date signed 11/29/40

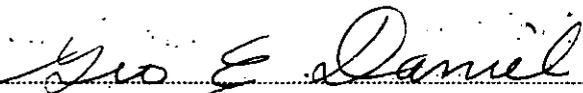
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED 10-10-40

STATEMENT BY LICENSED EMBALMER

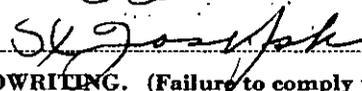
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by
 _____, Registered Apprentice No. _____
working under my personal supervision.

Signed



Licensed Embalmer No. 3300

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, fact should be so stated above.