DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 31 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42044

Registration District No. 398 Primary Registration District No. 5554 Registrar's No. 327

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Indep. Mo. Rt 11 Blvd 1 Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rt #1 7 mi N. East of 24 Highway
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 73 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Route #1 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rt #1-7 mi. N. East of 24 Highway 0
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Mrs Maude Jones

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race wh

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased July (Month) 2 (Day) 1866 (Year)

8. AGE: Years 75 Months 5 Days 6 If less than one day ..... hr. ..... min.

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

10. Usual occupation House Wife

11. Industry or business .....

FATHER
12. Name Charles Jackson Sampler
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Laura Taylor
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Mr Ernest Jones
(b) Address Indep. Mo. Rt #1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-41 (Month) (Day) (Year)
(c) Place: burial or cremation Salem Cemetery

18. (a) Signature of funeral director Ott + Mitchell
(b) Address Independence Mo.

19. (a) 12-10-41 (Date received local registrar) (b) F. L. Cook M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9
year 1941 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from March 23, 1941, to Dec 9, 1941; that I last saw her alive on Nov. 30, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Gastric Carcinoma	9 months
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Ha Cachectia & Nation	

Major findings:
Of operations .....
Of autopsy No 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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature C H Allen (M. D. or other) M.D.
Address Independence Mo. Date signed 12-9-41

360

(Licensed Embalmer's Statement on Reverse Side)

MAKE A PERMANENT RECORD

JAN 25 1958

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 Me

....., Registered Apprentice No.....

working under my personal supervision.

Signed Henry G. Mitche

Licensed Embalmer No. 3925

P. O. Address Indep. Mo

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

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
10M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42044

Registration District No. 398 Primary Registration District No. 3554 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Indep.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Maude Jones
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: July (Month) 2 (Day) 1866 (Year)
8. AGE: Years 75 Months 5 Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Gastric Carcinomia	
This is a clinical diagnosis - no laparotomy or post mortem. Was done and the exact anatomical location of the primary lesion cannot possibly be determined.	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operation:	
Of autopsy: 46	

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

23. Signature: C. H. Allen (M. D. or other) M.D.
Address: Independence, Mo. Date signed 2-4-42