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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 16 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____
Registrar's No. **1182**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 29 days
(Specify whether
In this community 16 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 3945 Fairfax
(If rural, give location)
(e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME Atlee Sampler
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Co 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 25 1916
(Month) (Day) (Year)

8. AGE: Years 26 Months 4 Days 6
If less than one day _____ hr. _____ min.

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

10. Usual occupation Lab

11. Industry or business _____

12. Name Thomas Sampler

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

14. Maiden name Bessie Fleming

15. Birthplace Newport Ark
(City, town, or county) (State or foreign country)

16. Informant Thomas Sampler

(b) Address 3945 Fairfax St 2-6-43

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-43
(Month) (Day) (Year)

(c) Place: burial or cremation Father Duckson

18. (a) Signature of funeral director A. D. Richard

(b) Address 2525 Delaney

19. (a) FEB 3 1943 (Date received local registrar) (b) J. P. Brudek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 1,
year 1943 hour _____ minute 30 A. M.
21. I hereby certify that I attended the deceased from January 3,
1943 to February 1,
1943
that I last saw him alive on February 1,
1943
and that death occurred on the date and hour stated above.

Immediate cause of death Brain Abscess (Left Frontal)
Duration 1 mo.

Due to Purulent Maxillary sinusitis (left) 1 mo.

Due to _____
Other conditions pink
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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?

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

23. Signature H. P. Williams (M. D. or other) _____
Address 2601 Whittier Date signed 2/2/43

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

MOTHER FATHER

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

A. J. Richards

Licensed Embalmer No. *2928*

P. O. Address *2625 Glasgow*

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.