No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JAN 19 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 292

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 48

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Flanagan Nursing Home
2018 Francis St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: ~~none~~ 1 yr 1 mo 1 day (Specify whether years, months or days)

In this community: 1 yr 1 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Buchanan

(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No.: 2018 Francis St
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Charles C Sampson

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: male

5. Color or race: white

6. (a) Single, widowed, married, divorced: widower

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

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

7. Birth date of deceased: 12-21-1879 (Month) (Day) (Year)

8. AGE: Years 68 Months 0 Days 13 If less than one day hr. min.

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

10. Usual occupation: Farmer

11. Industry or business:

MOTHER FATHER

12. Name: Ben Sampson

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

14. Maiden name: unknown

15. Birthplace: unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Alvie Wheeler

(b) Address: 5641 So 2nd St, St. Joe, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-7-48 (Month) (Day) (Year)

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

18. (a) Signature of funeral director: Barry Funeral Home

(b) Address: St. Joseph, Mo.

19. (a) 1-16-48 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 4 year 1948 hour 12 minute 01 A M.

21. I hereby certify that I attended the deceased from December 6, 1945, to December 23, 1947, that I last saw him alive on December 23, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Aortic Regurgitation	9 mos.
Due to: Lues	2 yrs.
Due to: XXXX	
Other conditions: XXX (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause of 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: Charles H. Werner (M. D. or other)

Address: Kirkpatrick Bldg. St. Joseph, Mo. Date signed: 1-6-48

(Licensed Embalmer's Statement on Reverse Side)

Jefferson City Printing Co.

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 Victor Bandy

Licensed Embalmer No. 4212

P. O. Address St Joseph Mo

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.