

FILED MAR 23 1950

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

11035

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 1009 Registrar's No. 2327

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis
c. LENGTH OF STAY (In this place) 30 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE _____ b. COUNTY _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis
d. STREET ADDRESS (If rural, give location) 22-236 50 Beaumont

3. NAME OF DECEASED
a. (First) Henry b. (Middle) _____ c. (Last) Sampson

4. DATE OF DEATH (Month) (Day) (Year)
March 5 1950

5. SEX Male

6. COLOR OR RACE Col

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH May 2, 1883

9. AGE (In years last birthday) 66

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTH PLACE (State or foreign country) Miss

12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Anthony Sampson

13b. MOTHER'S MAIDEN NAME Charity Rodgers

14. NAME OF HUSBAND OR WIFE Hattie B Sampson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME Hattie B Sampson ADDRESS 236 50 Beaumont

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Undetermined
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Chronic Pyelonephritis

INTERVAL BETWEEN ONSET AND DEATH
Undet.

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
4200

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 3-3, 1950, to 3-5, 1950, that I last saw the deceased alive on 3-5, 1950, and that death occurred at 9:55 a.m., from the causes and on the date stated above.

23a. SIGNATURE James J. Sedress (Degree or title) _____

23b. ADDRESS 2601 N Whittier St

23c. DATE SIGNED 3-7-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Shipped

24b. DATE Mar 11/50

24c. NAME OF CEMETERY OR CREMATORY Imola

24d. LOCATION (City, town, or county) (State) Miss

DATE REC'D BY LOCAL REG. MAR 10 1950 REGISTRAR'S SIGNATURE J. B. Lasater

25. FUNERAL DIRECTOR'S SIGNATURE F. G. Allen ADDRESS 4214 Delmar

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

[Handwritten signature]

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 _____

working under my personal supervision.

Student Embalmer No.

Signed *F. G. Green*

Signed
Student Embalmer

Licensed Embalmer No. *2963*

P. O. Address *4214 Delmar*

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.