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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7819**

BIRTH NO. **FILED APR 5 1954** REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **329**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	c. LENGTH OF STAY (in this place) 56 years	c. CITY OR TOWN DeKalb	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital		e. STREET ADDRESS (If rural, give location) R. R. #2	

3. NAME OF DECEASED (Type or Print) Delia G. Sampson	a. (First) Delia	b. (Middle) G.	c. (Last) Sampson	4. DATE OF DEATH (Month) (Day) (Year) March 19, 1954
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH November 19, 1882	9. AGE (In years) (last birthday) 71 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and State or Foreign Country) Rushville, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Allen Bundy	13b. MOTHER'S MAIDEN NAME Olive Garton	14. NAME OF HUSBAND OR WIFE L. C. Sampson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Lorene Prather, DeKalb, Missouri

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		INTERVAL BETWEEN ONSET AND DEATH 1 day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Thrombosis		unk.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 332X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) OFF? <input type="checkbox"/> INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec. 1, 1953**, to **Mar. 19, 1954**, that I last saw the deceased alive on **Mar. 18, 1954**, and that death occurred at **7:30 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>Marion E. Wagoner M.D.</i>	(Degree or title) M.D.	23b. ADDRESS 301 Illinois Ave., City	23c. DATE SIGNED 3-23-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 3/21/1954	24c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery	24d. LOCATION (City, town, or county) (State) DeKalb, Missouri
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DATE REC'D BY LOCAL REG. Mar. 27, 1954	REGISTRAR'S SIGNATURE <i>Lothar M. Allison</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Wheaton-Courtesy Funeral Home</i> St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *William Spalding*.....
Licensed Embalmer No. *453*

P. O. Address *3195 1st St. A*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.