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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 3 1958

323  
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 67

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph,</u>		c. CITY OR TOWN <u>St. Joseph,</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Osteopathic 6yrs</u>		d. STREET ADDRESS (If outside, give location) <u>1222 Powell</u>	
Length of stay in 1b <u>6yrs</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Edda</u> Middle <u>Sampson</u> Last <u>Sampson</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>17</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1880</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Iowa city unknown</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George Galbreath</u>	13b. MOTHER'S MAIDEN NAME <u>Annie Davis</u>	14. NAME OF HUSBAND OR WIFE <u>Edwar (de)</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Forest Sampson DeKalb, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>17 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>C. V. A.</u>	
	DUE TO (c) <u>Hypertension.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>		19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>Jan. 10, 1958</u> to <u>Jan. 17/58</u> and last saw her alive on <u>Jan. 16, 1958</u> Death occurred at <u>approx. 9:45 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Wm. R. Litchcomb D.O. 2</u>	22b. ADDRESS <u>1105 N. 26th St. Joseph, Mo. 1-20-58</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/19/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Westlawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>DeKalb, Mo</u>
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24. FEDERAL DIRECTOR ADDRESS <u>John E. Ruppert St. Joseph, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Jan. 27, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>
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(Licensed Emballer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *John E. Rupp* .....  
Licensed Embalmer No. *103986* .....  
P. O. Address *10 Joseph* .....

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.