

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013894
STATE FILE NUMBER

FILED MAY 4 1959 Registration District No. 169 Primary Registration District No. Registrar's No. 21

300
-57

1. PLACE OF DEATH a. COUNTY Knox		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Knox	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 5 mi NW Knox City		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN 5 mi NW Knox City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION residence		Length of stay in lb 7 yrs	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First CHARLES Middle MILTON Last SAMPSON			4. DATE OF DEATH Month Apr Day 28 Year 1959	
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5. SEX male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 28, 1896	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Goodland, Indiana	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Elmer Ellsworth Sampson	13b. MOTHER'S MAIDEN NAME Anna Mae Cowger	14. NAME OF HUSBAND OR WIFE Roberta G. Lowe
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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) yes World War I	16. SOCIAL SECURITY NO. 333-24-1714	17. INFORMANT Mrs. Charles M. Sampson	Address Knox City
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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) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis general DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Prostate Hypertrophy 4201		19. WAS AUTOPSY PERFORMED? 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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	ITEM 5 CORRECTED BY AFFIDAVIT OF Informant 8-11-1960
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20d. INJURY OCCURRED WHILE AT WORK <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 Knox City COUNTY _____ STATE _____
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21. I attended the deceased from **Jan 1, 59** to **Apr 28, 59** and last saw him alive on **April 21, 1959**
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ned B. Deon M.D. (Degree or title)	22b. ADDRESS Knox City Mo	22c. DATE SIGNED 4/30/59
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23a. BURIAL, CREMATION, REINTERMENT (Specify) burial	23b. DATE 1 May '59	23c. NAME OF CEMETERY OR CREMATORY Knox City Cemetery	23d. LOCATION (City, town, or county) (State) Knox City, Missouri
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24. FUNERAL DIRECTOR Hudson Funeral Home ADDRESS _____	25. DATE RECD. BY LOCAL REG. May-1-59	26. REGISTRAR'S SIGNATURE Dick S. Humeat
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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1959 MAY 4

1959 JUN 8

1959 MAY 8

1959 MAY 5

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 *A. G. Reimer*

Licensed Embalmer No. *504*
P. O. Address.. *Edina, Mn*

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.