

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016865  
STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 536

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo.Meth.Hosp.</b>		Length of stay in lb <b>30 years</b>	d. STREET ADDRESS (If outside, give location) <b>2207 Lovers Lane</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BETTY</b> Middle Last <b>SAMPSON</b>			4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1959</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1902</b>
9. AGE (In years last birthday) <b>56</b>		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) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	11. BIRTHPLACE (City and state or country) <b>Sweetwater, Wyo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>William Wilson</b>	
13b. MOTHER'S MAIDEN NAME <b>Janet Scott</b>		14. NAME OF HUSBAND OR WIFE <b>C. N. Sampson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Dr. C.M. Sampson, 2207 Lovers Lane</b>		Address <b>St. Joseph, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterial shock due to renal failure.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4.8 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Renal - azotemia - adhesion intestinal obstruction.</b>			<b>32 hrs.</b>
DUE TO (c) <b>Arteriosclerotic penetrating intracerebral cerebral vessel.</b>			<b>years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Subtotal gastric resection; 2 anterior gastrosplenostomy 5411</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
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 COUNTY STATE
21. I attended the deceased from <b>7 April</b> , to <b>death</b> , and last saw her alive on <b>17 May '59</b> Death occurred at <b>12:15 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Wilbur P. McDonald M.D.</b>		22b. ADDRESS <b>301 N. 8th St.</b>	22c. DATE SIGNED <b>19 May '59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/20/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph Mo.</b>
24. FUNERAL DIRECTOR <b>Horton-Bowman</b>		ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>May 21, 1959</b>
		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>	

All diseases in Part I must be causally related.  
 Dr. Wilbur P. McDonald  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

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 *Leque Wood* .....

Licensed Embalmer No. *3204* .....  
P. O. Address *314 So 10th, Ft Worth* .....

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.