MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

39556

File No. 11749

Registered No.

791
1003

1. PLACE OF DEATH

County

Registration District No.

Township

Primary Registration District No.

City ST LOUIS (No. 4956 Ashby St. Ward)

2. FULL NAME JOHN SAMSON

(a) Residence. No. 4956 ASHBY St., 7 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) DEC 8TH 1890

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
30	11	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work LABORER

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer HUSSMAN REFRIGERATOR CO.

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) AUSTRIA HUNGARIA

PARENTS

10. NAME OF FATHER ALBERT SAMSON

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) AUSTRIA HUNGARIA

12. MAIDEN NAME OF MOTHER MARY SCHULZ

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) AUSTRIA HUNGARIA

14. INFORMANT MARY FIRST
(Address) 4956 ASHBY AVE

15. FILED NOV 24 1931 Mary C. Turner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

No Physician in attendance

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 22 1931

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ..... 19....., and that
death occurred, on the date stated above, at 11:18 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asphyxiation
due to fuel gas poisoning
self administered, at residence
16 hrs. (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Suicide
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John Henry M.D.
11/23 1931 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery

DATE OF BURIAL Nov 25th 1931

20. UNDERTAKER Edward Koch

ADDRESS 3516 Ashby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD