

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

32609
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson 3 Registration District No. 400
 (b) Township Prairie 1 Primary Registration District No. 5553B Registered No. 180
 (c) City (d) Street No. Home St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Polly Sampson

(a) Residence, No. Jackson Co. Home St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec-25-1863

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>75</u>	<u>8</u>	<u>no</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) On High Seas

FATHER 13. NAME Unknown ?

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT E. Jackson
(ADDRESS) Home

18. BURIAL, CREMATION, OR REMOVAL Marionville Mo DATE Sept 3 1929

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Keller Bros
1620

20. FILED 9/3 1929 Sarah E. Barnes
Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 25 1939

22. I HEREBY CERTIFY, That I attended deceased from 8/1 1939 to 8-25 1939

I last saw her alive on 8/24 1939 Death is said to have occurred on the date stated above, at 8 P. m.
 The principal cause of death and related causes of importance were as follows:
Chronic myocarditis (Date of onset)

Other contributory causes of importance: None

Name of operation Date of
 What test confirmed diagnosis Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify
 (Signed) H. Green M. D.
 (Address) Independence Mo

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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
..... Licensed Embalmer No.....
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.