

NO. 2
-8-43
5-17-39
X37823

STANDARD CERTIFICATE OF DEATH

State File No. 36998

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 128

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Dr. Alex VanRavenwaay Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Weeks
(Specify whether years, months or days)

In this community 50 Years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper

(c) City or town Blackwater, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Lydia Sampson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 18
year 1945 hour 11 minute _____ p. M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife ?? 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: October 17 1885
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 18 1945 to Nov 18 1945
that I last saw he alive on Nov 18, 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 87 Months 1 Days 1 If less than one day
hr. _____ min. _____

Immediate cause of death: Pneumonia Duration 1 month

Due to fracture of right hip

Due to _____

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) None

10. Usual occupation Housewife

Major findings: Of operations None Of autopsy None

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

11. Industry or business At home

12. Name James Orsborn

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Anna Hyde

15. Birthplace England
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Perkins.

(b) Address Blackwater, Mo.

17. (a) Burial (b) Date thereof Nov. 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sweet Springs, Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? at home at Blackwater
(City or town) (County) (State) Mo.

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director Hoodman Hall

(b) Address Boonville, Mo.

(Specify type of place) _____ (e) Means of injury fell on porch

23. Signature W. B. Orsborn (M.D. or other) _____
Address Boonville, Mo. Date signed 11.19.45

19. (a) Nov 19 45 (b) _____
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

12-7-42

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

G. F. Boller

Licensed Embalmer No.

3062

P. O. Address

Boonville, Mo.

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 this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. De

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 128

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Lydia Sampson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Oct 17
(Month) (Day) (Year)

8. AGE: Years 87 Months _____ Days _____
If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Oct 22
to Nov 18, 19____;
that I last saw him _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
fracture neck R femur

Due to _____
hypostatic pneumonia and general debility

Other conditions _____
(Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Yes

(b) Date of occurrence Oct 22, 1945

(c) Where did injury occur at home Cooper Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on farm

While at work _____ (Specify type of place)

(e) Means of injury fell off porch

23. Signature Alvin Rowson (M. D. or other) _____

Address Boonville Mo. Date signed 12 17 45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

36998