

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18897

State File No.

FILED JUN 27 1949

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 4095 Registrar's No. 89

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| 1. PLACE OF DEATH a. COUNTY Cass | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cass | |
| b. CITY (If outside corporate limits, write RURAL and give township) Drexel, | | c. CITY (If outside corporate limits, write RURAL and give township) Drexel. | |
| c. LENGTH OF STAY (in this place) 3 yrs. | | d. STREET ADDRESS (If rural, give location) No street numbers. | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Not in hospital. At home. | | | |

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|-------------------------------------|-------------------------|--------------------------|---------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) AGNES | b. (Middle) HINES | c. (Last) SAMPSON. | 4. DATE OF DEATH (Month) (Day) (Year) June, 22, 1949 |
|-------------------------------------|-------------------------|--------------------------|---------------------------|---|

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|----------------------|-------------------------------|--|--|---|--|------------------------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed. | 8. DATE OF BIRTH Sept. 22, 1875 | 9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR: Months 9 Days 0 | IF UNDER 1 HR. Hours 0 Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home. | 10b. KIND OF BUSINESS OR INDUSTRY Household duties. | 11. BIRTHPLACE (State or foreign country) LeRoy, Ill. / | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME F. Patrick Hines. | 13b. MOTHER'S MAIDEN NAME Susan Craig. | 14. NAME OF HUSBAND OR WIFE Alfred Sampson. |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never; unknown) No. | 16. SOCIAL SECURITY NO. Does not apply. None. | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Charles Longacre, Decatur, Ar. | ADDRESS Decatur, Ar. |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 4 yr. |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arterio Sclerosis..... | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage. DUE TO (c) - | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | 4500 | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) - | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) - - - |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) - - - - - m. | 21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? - |
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22. I hereby certify that I attended the deceased from I/I6, 1949, to June, 22, 1949, that I last saw the deceased alive on June, 15, 1949, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

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| 23a. SIGNATURE Bess Overhull (M.D.) | (Degree or title) | 23b. ADDRESS Drexel, Missouri. | 23c. DATE SIGNED 6/22/49. |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial. | 24b. DATE 6/24/1949. | 24c. NAME OF CEMETERY OR CREMATORY Sharon Cemetery | 24d. LOCATION (City, town, or county) (State) Drexel, Mo. |
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| DATE REC'D BY LOCAL REG. 6/23/49. | REGISTRAR'S SIGNATURE Laura J. Jones. | 51 | 2. FURNISH DIRECTOR'S SIGNATURE [Signature] | ADDRESS Drexel, MO. |
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(Licensed Embalmer's Stamp to be on Reverse Side)

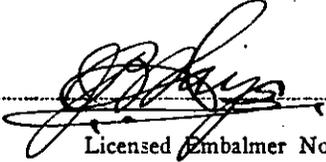
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 6 1949

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, ~~XXXX~~
personally. ~~XXXXXXXXXX~~
working under my ~~personal supervision.~~

Student
Student Embalmer

Signed 
Licensed Embalmer No. 1950

P. O. Address Drexel, Missouri.

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.