

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017886

STATE FILE NUMBER

FILED MAY 26 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 523

300
1-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield 0396 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1453 S. Jefferson Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First PEARL Middle T. Last SAMPSON			4. DATE OF DEATH Month May Day 19 Year 1958		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Nov. 1889	9. AGE (In years less birthday) 68	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Tarrant	13b. MOTHER'S MAIDEN NAME Alta Wilhite	14. NAME OF HUSBAND OR WIFE Herschel Sampson
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Herschel Sampson Springfield, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anesthesia (propofol + O2)		INTERVAL BETWEEN ONSET AND DEATH 12 min.
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____
DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1) Acute & chronic myocarditis 2) Rheumatic heart disease with mitral insufficiency 3) Acute and chronic pyelo-nephritis secondary to 4) nephrolithiasis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. TIME OF INJURY . Hour Month, Day, Year 1958		20c. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Springfield, Mo.	20d. CITY, TOWN, OR LOCATION Springfield	COUNTY Greene	STATE Missouri
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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.) Springfield, Mo.	20f. CITY, TOWN, OR LOCATION Springfield	COUNTY Greene	STATE Missouri
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21. I attended the deceased from **1956** to **Death** and last saw her alive on **5-19-58**
Death occurred at **10:07** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Herschel Sampson, M.D.</i>	(Degree or title)	22b. ADDRESS Springfield, Mo.	22c. DATE SIGNED 5-22-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/21/58	23c. NAME OF CEMETERY OR CREMATORY Greenlawn	23d. LOCATION (City, town, or county) Springfield, Missouri
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24. FUNERAL DIRECTOR J.W. Klingner & Co.	ADDRESS Spqfd. Mo.	25. DATE RECD. BY LOCAL REG. 5-23-58	26. REGISTRAR'S SIGNATURE Effie G. Melton
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

VS OCT 21 1981

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 *Catherine Flanagan*

Licensed Embalmer No. *3719*

P. O. Address

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.