

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045330

FILED VS. JAN 3 1961 47

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 340

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Callaway</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Length of stay in 1b <b>1 Day</b>		c. CITY OR TOWN <b>Fulton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Callaway Memorial</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>714 Bluff</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Penn</b> Last <b>Sampson</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>1960</b>					
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7/26/1872</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Callaway Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Andrew Sampson</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Nevins</b>			14. NAME OF HUSBAND OR WIFE <b>Maude Hudson Sampson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs Wallace Jones New Bloomfield Mo</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shrouns - cerebral vessels</b>							INTERVAL BETWEEN ONSET AND DEATH <b>± 24 hours</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <b>generalized arteriosclerosis</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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <b>8:30</b> a.m. <b>12/26/60</b> Month, Day, Year		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.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from <b>12/26/60</b> to <b>12/27/60</b> and last saw him alive on <b>12/26/60</b> Death occurred at <b>about 8:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Henry D. D. M.D.</b>				22b. ADDRESS <b>Fulton, Mo.</b>				22c. DATE SIGNED <b>12/29/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/29/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Salem Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Boone Co. Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Haupin Funeral Home Fulton Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Dec 29-1960</b>		26. REGISTRAR'S SIGNATURE <b>Martha Lawrence</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John Passon*  
\_\_\_\_\_  
Licensed Embalmer No. *2555*

P. O. Address *Hullon*

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.