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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

40375

1 PLACE OF DEATH

County Jasper

Township ~~Mineral~~ Barton

or

Village

or

City Oronogo (NO. ..... St.; ..... Ward)

Registration District No. 413 File No.

Primary Registration District No. 4245 Registered No. 4036

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James R Hampton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct. (Month) 27 (Day) 1917 (Year)

7 AGE 1 yrs. — mos. 6 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Mo.

PARENTS

10 NAME OF FATHER Arthur D Hampton

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo

12 MAIDEN NAME OF MOTHER Cora McCoy

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Cora Hampton

(Address) Oronogo Mo.

15

Filed Nov 10, 1918 J S Barson MD
by H. Barson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. (Month) 2 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 24, 1918, to Nov. 2, 1918, that I last saw him alive on Nov 2, 1918, and that death occurred, on the date stated above, at 7-30 a.m.

The CAUSE OF DEATH* was as follows:

Subsequent Pneumonia

109A

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Barson M. D.

Nov 2, 1918 (Address) Oronogo Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Weaver Cem

DATE OF BURIAL Nov 3, 1918

20 UNDERTAKER J. T. Stick Und Co

ADDRESS Webb City

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from .....191....., to .....191.....
that I last saw h.....alive on .....191.....
and that death occurred, on the date stated above, at .....m
The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs.....mos.....ds

CONTRIBUTORY .....
(Secondary)
..... (Duration) .....yrs.....mos.....ds

(Signed) .....M. D

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, stat (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ....., 191.....

20 UNDERTAKER | **ADDRESS**