

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

Do not use this space.

23789

1. PLACE OF DEATH

County Reynolds Registration District No. 1099
 Township Apple Springs Primary Registration District No. 5868
 City Harrell (No. _____ St. _____ Ward _____)

2. FULL NAME

Clare Hampton
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-4-1906

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
24 4 12

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

9. BIRTHPLACE (CITY OR TOWN) Pascala
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Joseph Hampton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Pascala
 (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Martha Evelyn Trench

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Harrell
 (STATE OR COUNTRY) Mo

14. INFORMANT Cecil Hampton
 (Address) Harrell Mo.

15. FILED 7-25-30 Ma Hickman
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July, 16th 1930

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1930, 1930, to July 16, 1930, 1930, that I last saw h. in alive on July, 16, 1930, and that death occurred, on the date stated above, at 6-30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Malarial fever primarily

120 B
38 117 B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Appendicitis
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS None
 (Signed) A. A. Fisher, M. D.
 , 19 (Address) Portageville, Mo.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____
 19

20. UNDERTAKER ✓ ADDRESS _____

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.

30 1930

