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.

DEC 8 JUL 12 1939

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

20634
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 701

(b) Township ..... Primary Registration District No. 1008 Registered No. 5478

(c) or City St. Louis (d) Street No. Homer Phillips Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 13 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 513 Clarence Hampton

(a) Residence, No. 2308 R LaSalle St. 22
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: C
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ~~June 15,~~ May 2 1925

7. AGE: YEARS 14 MONTHS 1 DAYS 13 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

FATHER
13. NAME Clinton Hampton
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

MOTHER
15. MAIDEN NAME Addie Baker
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

17. INFORMANT (ADDRESS) Evelyn Hilliard 2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL
PLACE Washington Park DATE June 20th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. L. Beal Und Co. 2726 Lucas ave

20. FILED JUN 20 1939 19 J. F. Bredeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 15, 1939 19

22. I HEREBY CERTIFY, That I attended deceased from May 14, 1939, 19, to June 15, 1939, 19
I last saw him alive on June 15, 1939, 19 Death is said to have occurred on the date stated above, at 10:30 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary tuberculosis	5/14/39

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Wallace Fingal, M. D.
(Address) 2601 N Whittier

(Licensed Embalmer's Statement on Reverse Side)

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 William C. McDowell, Registered Apprentice No. ..... working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2114

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.