

FILED APR 22 1940 282

Primary Registration District No. **4166**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: **Campbell Dunklin**
 (a) County _____
 (b) City or town **Marion**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town **Marion** (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME **George W Hampton**
 8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **March** day **15** year **1940** hour **8** minute **2** M.
 21. I hereby certify that I attended the deceased from **Mar 14** ~~March 14~~, 1940, to **Mar 25**, 1940, that I last saw him alive on **Mar 1**, 1940, and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Bertha Hampton** 6. (c) Age of husband or wife if alive **36** years
 7. Birth date of deceased **Aug-31-1860** (Month/Day/Year)

Immediate cause of death **Drops**
 Due to **Kidney Trouble**
 Due to **Over**
 Other conditions (Include pregnancy within 3 months of death) **123**

8. AGE: Years **79** Months **7** Days **15** If less than one day _____ hr. _____ min.
 9. Birthplace **Jenni** (City, town, or county) (State or foreign country) **1**
 10. Usual occupation **Farming**

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 Major findings: _____
 Of operations _____
 Of autopsy _____

MOTHER FATHER
 12. Name **Wick** **9**
 13. Birthplace _____ (City, town, or county) (State or foreign country) **11**
 14. Maiden name **Wick**
 15. Birthplace _____ (City, town, or county) (State or foreign country) **1**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? **256**
 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature **John T Brown** (M. D. or other) **1**
 Address **Campbell Mo** Date signed _____

16. (a) Informant **Bertha Hampton wife**
 (b) Address **Campbell Mo**
 17. (a) **Burnett** (b) Date thereof **Mar-15-40** (Month) (Day) (Year)
 (Burial, cremation, or removed)
 (c) Place: burial or cremation **Your wife**
 18. (a) Signature of funeral director **Friendly County**
 (b) Address **Campbell Mo**
 19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

1320

RECEIVED

District Health Officer No. 2

District File Number 440-94

Date Filed 4/12/48

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.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10843**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **282**

Primary Registration District No. **4166**

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Dunklin**
(b) City or town **Campbell**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Geo W. Hampton

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex **M**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased.....

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
79	7	5	hr. min.

9. Birthplace.....

(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace.....

(City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a).....

(b) Date thereof.....

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **3-15-40**

(Date received local registrar)

(b)

[Signature]
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Dunklin**
(c) City or town **Campbell**
(If outside city or town limits write "RURAL")
(d) Street No.....
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **15**
year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death **M. M. D. as reported**
Due to **gumery -**
Due to **10-9-40**

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury

23. Signature **John T. Brown** (M. D. or other)
Address **Campbell** *[initials]* signed.

S-10843

1940