

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.

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

32939
Do not use this space.

1. PLACE OF DEATH *Reynolds J. 8*
 (a) County *Reynolds* Registration District No. *748*
 (b) Township *St. Louis* Primary Registration District No. *4449* Registered No. _____
 (c) City *Ellington* (d) Street No. _____
 (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Mahesa Hampton*
 (a) Residence, No. *Ellington, Mo.* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Remarried*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Walter Hampton*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *4/9-1855*
 7. AGE YEARS *86* MONTHS *5* DAYS *22* If LESS than 1 day,hrs. ormin.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Retired*
 10. Date deceased last worked at this occupation (month and year) *1/1940* 11. Total time (years) spent in this occupation *19*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10/1*, 19*40*
 22. I HEREBY CERTIFY, That I attended deceased from *9/28*, 19*40*, to *10/1*, 19*40*
 I last saw h. w. alive on *9/30*, 19*40* Death is said to have occurred on the date stated above, at *1:20 PM*.
 The principal cause of death and related causes of importance were as follows:
Cerebral Apoplexia Date of onset *9/28/40*
 Other contributory causes of importance: *Hypertension, Atherosclerosis*
 Name of operation *None* Date of _____
 What test confirmed diagnosis? _____ 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) *J. Skellern* M. D.
 (Address) *Ellington, Mo.*

12. BIRTHPLACE (CITY OR TOWN) *Mo.* (STATE OR COUNTRY) *0*
 FATHER 13. NAME *Turner Hampton*
 14. BIRTHPLACE (CITY OR TOWN) *Kent* (STATE OR COUNTRY) *0*
 MOTHER 15. MAIDEN NAME *Barbara DeWey*
 16. BIRTHPLACE (CITY OR TOWN) *Mo.* (STATE OR COUNTRY) *0*
 17. INFORMANT *Sam Rouse* (ADDRESS) *Ellington, Mo.*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Hampton Cemetery* DATE *10/19*, 19*40*
 19. FUNERAL DIRECTOR (NAME) *W. J. Evans* (ADDRESS) *671*
 20. FILED *10/3*, 19*40* *Essie Evans* Local Registrar.

RECEIVED

District Health Officer No. 5,

District File Number...1040020

Date Filed

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. 329397

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 748

Primary Registration District No. 4449

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Reynolds

(b) City or town Ellington
(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)

3. (a) PRINT FULL NAME Malissa Hampton

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced Div

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 85 Months 5 Days 22 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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 10 day 1
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 Cerebral apoplexy

Due to _____ 131

Due to _____

Other conditions Nephritis, Pharynx arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____

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 J. H. Kalls (M. D. or other) _____

Address _____ Date signed 7/4-40

