

0-4-41  
17-39  
X29484

FILED SEP 12 1944

Registration District No. 177 Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Calloway

(b) City or town Burlington  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
State Hosp No 1 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 D  
(Specify whether)

In this community same  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan

(c) City or town Epasure  
(If outside city or town limits, write "RURAL") 2

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM B HAMPSON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31 year 1944 hour 1 minute 0 M.

21. I hereby certify that I attended the deceased from Aug 17 1944 to Aug 31 1944  
that I last saw him alive on Aug 31 1944  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Delia Elvira Hampson 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased March 28 1867  
(Month) (Day) (Year)

Immediate cause of death Tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE: Years 75 Months 5 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business same

12. Name William Hampson

13. Birthplace England (City, town, or county) (State or foreign country)

14. Maiden name Elvira Whitaker

15. Birthplace Virginia (City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Recorder

(b) Address State Hosp No 1

17. (a) Removal (b) Date thereof 9-1-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Epitaph Rd

18. (a) Signature of funeral director James B. Nichols

(b) Address Epitaph Rd

19. (a) 9-1-1944 (b) John Morawickoff  
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury \_\_\_\_\_

23. Signature R. P. [unclear] (M. D. or other) \_\_\_\_\_

Address Venture mo 1 Date signed 8/31/44

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

MOTHER FATHER

JUN 18 1956

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 9-9-44.....

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 *me*

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *Jessie E. Richard*  
Licensed Embalmer No. *2466*  
P. O. Address *Lepton, Me*

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept.  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Callaway

(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Wm. B. Hampson

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 69 years

7. Birth date of deceased Mar 28 (Month) (Day) (Year)

8. AGE: Years 75 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Mo (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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 31 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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)  
(c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

**SUPPLEMENTAL**

27381