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FILED SEP 10 1944

Registration District No. 297

Primary Registration District No. 4328

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Bertrand
(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 14 Years

years, months or days)

3. (a) PRINT FULL NAME Robert Wade Hampton

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

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife ----- 6. (c) Age of husband or wife if

7. Birth date of deceased. October 5th 1865
(Month) (Day) (Year)8. AGE: Years 78 Months 9 Days 21 If less than one day
hr. min.9. Birthplace N.K. Tenn.
(City, town, or county) (State or foreign country)10. Usual occupation Farmer (retired)

11. Industry or business -----

12. Name William Wade Hampton13. Birthplace N.K. Tenn.
(City, town, or county) (State or foreign country)14. Maiden name Nancy McChristian15. Birthplace N.K. Tenn.
(City, town, or county) (State or foreign country)16. (a) Informant Alice Taber(b) Address Bertrand, Mo.17. (a) Burial (b) Date thereof: 7-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Oak Grove Charleston, Mo.18. (a) Signature of funeral director Charles L. ... (Specify type of place) While at _____ (c) Means of injury _____(b) Address 711/4419. (a) 7/1/44 (b) Mrs. Lon ... 23. Signature ... (M. D. or other) _____
(Date received local registrar) (Registrar's signature) Address ... Date signed _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss.(c) City or town Bertrand
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26th
year 1944 hour 2 minute 15 P M.21. I hereby certify that I attended the deceased from July 21, 1944 to July 26, 1944
that I last saw him alive on July 25, 1944
and that death occurred on the date and hour stated above.Immediate cause of death apoplexy

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? _____

23. Signature _____ (M. D. or other) _____

Address ... Date signed _____

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

RECEIVED
District Health Office No. 2,
District File Number 9-44-1209
Date Filed 9-8-44

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

Signed Not Embalmed
.....
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, fact should be so stated above.