

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

FILED FEB 19 1945

7329

Do not use this space.

1. PLACE OF DEATH

(a) County Shannon Registration District No. 336
(b) Township Winona Primary Registration District No. 4494 Registered No. _____
(c) City Winona (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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 Paul Hampton

(a) Residence, No. Winona, Mo. St. (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 W 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) Nov 5-1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
16 2 28

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Student
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) Annapolis, Md.

FATHER
13. NAME Wade H Hampton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER
15. MAIDEN NAME Kola Belle Williams

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Regdew H Hampton, Winona, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Winona DATE 3-2-45

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. T. Rudy, Winona, Mo.

20. FILED 2-3-45 1945 Crash, Winona, Mo. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-2-1945

22. I HEREBY CERTIFY, That I attended deceased from 2-1-45, 1945, to 2-2-45, 1945

I last saw him alive on 2-2-45, 1945. Death is said

to have occurred on the date stated above, at 5 P. m.

The principal cause of death and related causes of importance were as follows:

Influenza + Pneumonia Date of onset 1-29-45

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) W. T. Rudy, M. D.

(Address) Winona, Mo.

RECEIVED

District Health Officer No. 5,

District File Number

945-103

Date Filed

2-17-45

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.