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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED FEB 13 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

2581

State File No. _____

Registration District No. **318** Primary Registration District No. _____ Registrar's No. **100** **1105**

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

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or HOMER G. PHILLIPS HOSPITAL
 (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 John E Hampton
3. (b) If veteran no **3. (c) Social Security No.** _____
 name war _____

4. Sex M **5. Color or race** col
6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife Mathe Hampton **6. (c) Age of husband or wife if alive** deceased
7. Birth date of deceased May 15 1885
 (Month) (Day) (Year)

8. AGE: Years 62 Months 8 Days 16 If less than one day
 hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business chipper scullin steel
12. Name John E Hampton
13. Birthplace Missouri
 (City, town, or county) (State or foreign country)
14. Maiden name Sarah Scott
15. Birthplace MO
 (City, town, or county) (State or foreign country)

16. (a) Informant Ida Cobb
(b) Address 2018 1/2 Cole St

17. (a) Burial **(b) Date thereof** 2-5-48
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Home

18. (a) Signature of funeral director W. H. Green
(b) Address 397 Cascade Ave

19. (a) FEB 7 1948 **(b)** J. F. Bredebeck
 (Date received by Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 16 S. Channing
18 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31
 year 1948 hour _____ minute 15 P.M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 (that I last saw h. _____ alive on _____, 19____,
 and that death occurred on the date and hour stated above.)

Immediate cause of death Chronic Myocarditis
Intermittent Regurgitation
Arteriosclerosis of the Aorta
Due to _____
Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

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)
Signature W. H. Green (M. D. or other)
Address 397 Cascade Ave **Date signed** 2/3/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

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. 1173

P. O. Address 3517 Parkside av

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.