

FILED APR 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10121
State File No. 2820
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

10

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION 14 00 Spring 1		d. STREET ADDRESS (If rural, give location) 14 00 Spring 0'	

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) Milinda	c. (Last) Hampton	4. DATE OF DEATH (Month) (Day) (Year) 3-26-49
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 10-12-1868	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St James Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Arthur Hughes	13b. MOTHER'S MAIDEN NAME Sarah Rose	14. NAME OF HUSBAND OR WIFE Charles Hampton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Anna Bowling	ADDRESS St Louis Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 14 months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		97 3312	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 18, 1948, to Mar 26, 1949, that I last saw the deceased alive on Mar 25, 1949, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE Paul Vinyard, M.D. (Degree or title)	23b. ADDRESS 3718A Olive St St Louis 8 Mo	23c. DATE SIGNED 3-26-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-28	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Farmington Mo
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 29 1949 J. B. Fasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service
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2820

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....
Student Embalmer

Signed *J Allen Davis Jr*
Licensed Embalmer No. *405-3*
P. O. Address *Atlanta 10-M*

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.