No. 300
10.48

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

FILED SEP 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Hampton

State File No. 29052

BIRTH NO. _____ REG. DIST. NO. 355 PRIMARY REG. DIST. NO. 6204 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: Texas
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arroll, Mo Rural
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): None

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: TEXAS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL - DATE
d. STREET ADDRESS (If rural, give location): 10 MILE S.W. SUMMERSVILLE

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): W
c. (Last): Kaut

4. DATE OF DEATH (Month) (Day) (Year): May, 9 1949

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept, 17, 1870
9. AGE (In years last birthday): 78 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St, Louis, Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: George Kaut
13b. MOTHER'S MAIDEN NAME: Margret O Sullivan
14. NAME OF HUSBAND OR WIFE: Harriett Kaut

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S SIGNATURE OR NAME: Harriett Kaut, Arroll, Mo — ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

5 yr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 47, *to* May 9, 49, *that I last saw the deceased alive on* May 9, 49, *and that death occurred at* 5P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dr Laviere Hampton M.D.
23b. ADDRESS: Summersville
23c. DATE SIGNED: June 1

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: May 11, 49
24c. NAME OF CEMETERY OR CREMATORY: Arroll Cem.
24d. LOCATION (City, town, or county) (State): Arroll, Missouri

DATE REC'D BY LOCAL REG.: 8-22-49
REGISTRAR'S SIGNATURE: Anna Roberts 432
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Duncan Funeral Home, Mtn View, Mo

(Licensed Embalmer's Statement on Reverse Side)

Recei
Texas
8-29
11:00

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.

Student .....
Student Embalmer

Signed Joe B. Duncan

Licensed Embalmer No. 4325

P. O. Address Mta View Mo

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.