No. 300
10-48

FILED JAN 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Hampton
State File No. 43971

BIRTH NO. _____ REG. DIST. NO. 355 PRIMARY REG. DIST. NO. 4520 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: Texas
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Summersville
c. LENGTH OF STAY (in this place): 7 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Shannon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Summersville
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Henry b. (Middle) Austin c. (Last) Morton
4. DATE OF DEATH (Month) (Day) (Year): Dec 10-49
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 29-1873
9. AGE (In years last birthday): 76 — If under 1 year: Months 5 Days 11 — If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chamoy, Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: Elijah Morton
13b. MOTHER'S MAIDEN NAME:
14. NAME OF HUSBAND OR WIFE: Martha Morton
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.:
17. INFORMANT'S SIGNATURE OR NAME: R H Morton ADDRESS: Summersville, Mo.

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — 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) Cardiac insufficiency
DUE TO (c) Arterial Hypotension

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

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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* Jan 7, 1948, *to* Dec 10, 1949, *that I last saw the deceased alive on* Dec 10, 1949, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Dr. Lavere Hampton (Degree or title) D.O.
23b. ADDRESS: Summersville
23c. DATE SIGNED: Jan 5

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-12-49
24c. NAME OF CEMETERY OR CREMATORY: Summersville
24d. LOCATION (City, town, or county) (State): Summersville, Mo.

DATE REC'D BY LOCAL REG.: Jan 10-50
REGISTRAR'S SIGNATURE: Anna Roberts 433
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Duncan Funeral Home Mtn View, MO

(Licensed Embalmer's Statement on Reverse Side)

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

Recei
Expo
1-16
4.00

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 John F. Duncan

Licensed Embalmer. No. 2516

P. O. Address Mtn Grove 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.