

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18690

State File No. _____

2303

FILED JUN 16 1955

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give town) KANSAS City	c. LENGTH OF STAY (in this place) 39 yrs.	c. CITY OR TOWN KANSAS City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH HOSPITAL		STREET ADDRESS (If rural, give location) 1205 BENNINGTON 328	

3. NAME OF DECEASED (Type or Print)	a. (First) ETTA	b. (Middle) FRANCES	c. (Last) HAMPTON	4. DATE OF DEATH (Month) (Day) (Year) MAY-28-1955
-------------------------------------	-----------------	---------------------	-------------------	---

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 19-1882	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days Hours Mins. - - -	IF UNDER 24 HRS. Hours Mins. - -
---------------	------------------------	--	-------------------------------	------------------------------------	---	----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	-------------------------------------

13a. FATHER'S NAME John D. Creamer	13b. MOTHER'S MAIDEN NAME Dorella May	14. NAME OF HUSBAND OR WIFE Wm. V. Hampton
------------------------------------	---------------------------------------	--

15. HAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs. Earl Hampton	ADDRESS 1209 Bennington
---	-------------------------------	---	-------------------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 410X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cerebral Embolism		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Mitral Stenosis DUE TO (c) Rheumatic Mitral Endocarditis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--

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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Russell W. Kerr MD	Degree or title	23b. ADDRESS St Joseph Hosp.	23c. DATE SIGNED 28 May 55
-----------------------------------	-----------------	------------------------------	----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 31-1955	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cem.	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
--	-----------------------	--	--

DATE REC'D BY LOCAL REG. 5-28-55	REGISTRAR'S SIGNATURE new mitchell	25. FUNERAL DIRECTOR'S SIGNATURE C. H. Blackman Son 7 m.	ADDRESS
----------------------------------	------------------------------------	--	---------

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

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.....
Signature of Student Embalmer

Signed *W.C. Rivine*.....

Licensed Embalmer No. *487*.....

P. O. Address *H.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.