

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019753

STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

FILED JUN 13 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5505

300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Montgomery Co.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Litchfield</b> <i>8120 p</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		Length of stay in lb <b>4 Days</b>	d. STREET ADDRESS (If outside, give location) <b>32 125 Sherman St.</b>
3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>Marie</b> Last <b>Hampton</b>			4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years last birthday) <b>57</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>Litchfield, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Jacob Bailey</b>		13b. MOTHER'S MAIDEN NAME <b>Daisy Follis</b>	14. NAME OF HUSBAND OR WIFE <b>William Clyde Hampton</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Doris Mae Strate, 3550 St. Christopher Lane</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular (arterial) occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of parotid salivary gland</b>			90 yrs
DUE TO (c) <b>(Lungs)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>142.0</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>216645</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>3/25/58</b>
21. I attended the deceased from <b>2/16/45</b> to <b>3/25/58</b> and last saw her alive on <b>5/25/58</b> Death occurred at <b>10:20 pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Dorothy M. D.</b>		22b. ADDRESS <b>37 W Washington</b>	22c. DATE SIGNED <b>5/26/58</b>
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-26-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Litchfield, Ill.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 26 58</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith MD</b>

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 John J. Haines  
Licensed Embalmer No. 4108

P. O. Address Rock Hill, S.C.

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.