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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024727

STATE FILE NUMBER

FILED AUG 1 1958 Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 467

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1-57

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY New Madrid	
b. CITY OR TOWN Poplar Bluff Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Parma Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		d. STREET ADDRESS (If outside, give location) Route 2	
Length of stay in lb 23 days		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First CHARLEY Middle MARTIN Last HAMPTON			4. DATE OF DEATH Month July Day 18, Year 1958		
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5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/97	9. AGE (In years lost birthday) 61	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Dunklin Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME CHARLES HAMPTON	13b. MOTHER'S MAIDEN NAME ANNIE SHEPPARD	14. NAME OF HUSBAND OR WIFE Vina Hampton
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes NWI	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address VA Hospital Records
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUODENAL ULCER, ACTIVE, ACUTE.		INTERVAL BETWEEN ONSET AND DEATH 1 Month.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	(b) MASSIVE GASTRO-INTESTINAL HEMORRHAGE.	8 Hours.
	(c) CIRRHOSIS OF LIVER, CHRONIC, SEVERE.	Years.
	(d) BRONCHIECTASIS, CHRONIC, SEVERE.	Years.
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 YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from June 25, 1958 to July 18, 1958 Death occurred at 445 W. Main St. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (degree or title) EDWARD D. MEYER, M.D., Ward Physician	22b. ADDRESS VAH., POPLAR BLUFF, MO.	22c. DATE SIGNED 7/21/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-19-58	23c. NAME OF CEMETERY OR CREMATORY Vinson Cem.	23d. LOCATION (City, town, or county) (State) Walden, Mo.
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24. FUNERAL DIRECTOR ADDRESS Frank-Cotrell Poplar Bluff, Mo.	25. DATE RECD. BY LOCAL REG. 7/26/58	26. REGISTRAR'S SIGNATURE [Signature]
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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Name of Deceased: *John Doe*
 Date of Death: *July 15, 1958*
 Place of Death: *Home*
 Name of Undertaker: *John Doe*
 Address of Undertaker: *123 Main St, City, State*
 Name of Embalmer: *John Doe*
 Address of Embalmer: *123 Main St, City, State*
 Name of Hospital: *St. Mary's Hospital*
 Address of Hospital: *123 Main St, City, State*
 Name of Physician: *Dr. J. K. Smith*
 Address of Physician: *123 Main St, City, State*
 Name of Funeral Home: *John Doe*
 Address of Funeral Home: *123 Main St, City, State*

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 *Charles E. Mungl* _____

July 15, 1958 Licensed Embalmer No. *477*

P. O. Address *John Doe*

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.