

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013321

STATE FILE NUMBER

FILED APR 20 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1700

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2006 Wabash</b>		Length of stay in lb <b>Unknown</b>	d. STREET ADDRESS (If outside, give location) <b>2006 Wabash</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MOSE</b> Middle <b>HAMPTON</b> Last <b>HAMPTON</b>			4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 8, 1917</b>
9. AGE (In years last birthday) <b>42</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>tree trimmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	11. BIRTHPLACE (City and state or country) <b>Mississippi</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>William Hampton</b>	
13b. MOTHER'S MAIDEN NAME <b>Katie Menyard</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Charity H. Bentley - 446 S. Church St.</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>Intra cranial Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Penetrating Gunshot Wound of Face.</b> DUE TO (c) <b>Penetrating Gunshot Wound of Face.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I) <b>981X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>gunshot wound</b>	
20c. TIME OF INJURY Hour <b>9:30</b> p.m. Month, Day, Year <b>4/2/1959</b>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>2006 Wabash</b>		20f. CITY, TOWN, OR LOCATION <b>Kansas City Jackson, Mo</b>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Deputy Coroner</b>		22b. ADDRESS <b>1618 Lydia Ave</b>	
22c. DATE SIGNED <b>4/2/59</b>		22d. (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>4-4-59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>-</b>		23d. LOCATION (City, town, or county) <b>Jackson, Tenn.</b>	
24. FUNERAL DIRECTOR <b>E. Sterling Bills</b>		25. DATE RECD. BY LOCAL REG. <b>4-3-59</b>	
26. REGISTRAR'S SIGNATURE <b>Irene Marshall</b>		26. REGISTRAR'S SIGNATURE	

Locust, 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

L. M. Tillman

MEDICAL CERTIFICATION

**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 .....

Licensed Embalmer No. 3178 .....

P. O. Address 1212 Vine St., Kansas

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.