

FILED VS AUG 3 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-027487

STATE FILE NUMBER

Registration District No. 317

Primary Registration District No. 542

Registrar's No. 1968

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ferguson</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Vinita Park 4270</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hill Top House</b>		Length of stay in lb <b>1 Yr. 4 Mo.</b>	d. STREET ADDRESS (If outside, give location) <b>8112 Monroe</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>A.</b> Last <b>Hampton</b>			4. DATE OF DEATH Month <b>7</b> Day <b>20</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/27/82</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman (ret.)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Casket</b>	11. BIRTHPLACE (City and state or country) <b>Memphis, Tenn.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Wade Hampton</b>	13b. MOTHER'S MAIDEN NAME <b>Jennie Beckham</b>	14. NAME OF HUSBAND OR WIFE <b>Lola Hampton</b>
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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>unk.</b>	17. INFORMANT <b>Mrs. Lewis F. Lueking</b>	Address <b>7278 Country Club Dr.</b>
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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) <b>Carcinoma of descending Colon with metastases</b>		INTERVAL BETWEEN ONSET AND DEATH <b>-</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1532</b>		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>2</b>
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20c. TIME OF INJURY Hour <b>7:40</b> Month <b>July</b> Day <b>20</b> Year <b>1959</b>	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.)	20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>May 1 - 1958</b> to <b>July 20 - 1959</b> and last saw <sup>her</sup> him alive on <b>July 20 - 1959</b> Death occurred at <b>7:40 a.m.</b> 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) <b>John G. Murfley M.D.</b>	22b. ADDRESS <b>5014 Thekla Av.</b>	22c. DATE SIGNED <b>7/20/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>7/22/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b>
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24. FUNERAL DIRECTOR <b>Drehmann-Harral</b>	ADDRESS <b>1905 Union Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>7-22-59</b>	26. REGISTRAR'S SIGNATURE <b>John G. Murfley M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *Warren A. Carve* .....

Licensed Embalmer No. *3534* .....

P. O. Address .....

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.