

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039165

FILED VS NOV 17 1959

STATE FILE NUMBER

Registration District No. 389 Primary Registration District No. 5159 Registrar's No. 10

ENDED

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Caldwell Twp</u>		Length of stay in 1b <u>21 Yrs</u>	c. CITY OR TOWN <u>New Bloomfield</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D.# 2</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Ann</u> Last <u>Hampton</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/11/1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Portland, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Tharp</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Amos L. Hampton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>A. L. Hampton, New Bloomfield,</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-asthma</u> DUE TO (b) <u>Endo carditis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)	
20c. TIME OF INJURY. Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 COUNTY STATE	

21. I attended the deceased from 11-9-1959 to 11-13-59 and last saw him alive on 11-9-1959
Death occurred at 3⁰⁰ a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W.D. Payne M.D.</u>		22b. ADDRESS <u>R #3 Fulton Mo</u>		22c. DATE SIGNED <u>11-13-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 15, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reform Church Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Reform Callaway Mo</u>	

24. FUNERAL DIRECTOR ADDRESS <u>Wallace Funeral Home Fulton Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-14-59</u>	26. REGISTRAR'S SIGNATURE <u>Felroy Claypool</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *J. R. Masune*

Licensed Embalmer No. 4996
P. O. Address Fulton, Me

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.