

**FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 3 0 1959

**59-041915**

STATE FILE NUMBER

**210640**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Warren</b>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		c. CITY OR TOWN <b>Wright City</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>SALLIE</b> Middle <b>S.</b> Last <b>HAMPTON</b>			4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>17</b> Year <b>1959</b>		
5. SEX <b>Female</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>7/2/1875</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Arkansas</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>Thomas Jack St. John</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Ann Mustine</b>	
14. NAME OF HUSBAND OR WIFE <b>Todd 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>None</b>	
17. INFORMANT <b>Mrs. Minnie Neibert, 1126 Belgrove Dr.</b>		17. ADDRESS			

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>ACUTE MYOCARDIAL INFARCTION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 MINUTES</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		<b>15 YEARS</b>
DUE TO (c) <b>420-0</b>		
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 **JULY 29, 1956** to **NOV. 17, 1959** and last saw her alive on **NOV. 17, 1959**  
Death occurred at **4:45 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. O. Vermillion, M.D.</i>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>11/18/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-20-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Beth Cemetery</b>
23d. LOCATION (City, town, or county) <b>Rhineland, Mo.</b>		

24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 18 1959</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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*S.P.*

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 Harvey Kihler

Licensed Embalmer No. 4576

P. O. Address St Paul

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.