

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003502

FILED VS FEB 11 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-1272** STATE FILE NUMBER

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| 1. PLACE OF DEATH<br>a. COUNTY   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>                 | Length of stay in 1b<br><b>2 1/2 Months</b> | c. CITY OR TOWN <b>St. Charles</b>   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b> |   | d. STREET ADDRESS (If outside, give location)<br><b>118 Connie Drive,</b>  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|   |                                  |   |   |                                     |  |
|---|----------------------------------|---|---|-------------------------------------|--|
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>EVA</b> Middle <b>G.</b> Last <b>HAMPTON</b> |                                  |   | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>3rd</b> Year <b>1960</b> |                                     |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-21-1911</b>                                     | 9. AGE (last birthday)<br><b>48</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ |

|   |   |   |   |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Assembly Line</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Fisher Body Co.</b> | 11. BIRTHPLACE (City and state or country)<br><b>Graham, Kentucky</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
|---|---|---|---|

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|---|---|---|
| 13a. FATHER'S NAME<br><b>William Barrington</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Lennie Tate</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Rufus Hampton</b> |
|---|---|---|

|  |   |   |                            |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>486-20-5732</b> | 17. INFORMANT<br><b>Rufus E. Hampton, 118 Connie, St. Charles</b> | Address<br><b>Missouri</b> |
|--|---|---|----------------------------|

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|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRAIN TUMOUR</b><br><b>(GLIOBLASTOMA)</b><br>DUE TO (b) _____<br>DUE TO (c) <b>193.0</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 Mo's.</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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____<br>a.m. _____<br>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 **4-30-54** to **2-3-60** and last saw her alive on **2-2-60**  
Death occurred at **2-3-60** **12:50A** m on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                      |                                   |
|--|--------------------------------------|-----------------------------------|
| 22a. SIGNATURE<br><b>Robert Elach M.D.</b> | 22b. ADDRESS<br><b>35 N. Central</b> | 22c. DATE SIGNED<br><b>2-3-60</b> |
|--|--------------------------------------|-----------------------------------|

|   |                            |   |   |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>2-6-60</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, County, Missouri</b> |
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| 24. FUNERAL DIRECTOR<br><b>CALVIN F. FEUTZ, 4828 Natural Bridge Bl.,<br/>FUNERAL HOME, St. Louis, 15, Missouri</b> | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 3 1960</b> | 26. REGISTRAR'S SIGNATURE<br><b>Loan Smith, M.D.</b> |
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John A. Mles

Licensed Embalmer No. 4186

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.