

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3564 **63-046410**

FILED DEC 16 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u>		Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>Meecham Park</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>224 New York</u>	
3. NAME OF DECEASED (Type or print) <u>HAMPTON</u>			4. DATE OF DEATH <u>November 19, 1963</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8/14/1918</u>	
9. AGE (last birthday) <u>45</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>		11. BIRTHPLACE (City and state or country) <u>Aberdeen, Mississippi</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>ANDY HOGAN</u>			
13b. MOTHER'S MAIDEN NAME <u>GEORGIA HODGES</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.II</u>		17. INFORMANT <u>Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown natural causes</u>		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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 <u>Clayton, Missouri</u>		COUNTY _____ STATE _____	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>D O A Co. Hosp. 12:20 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Raymond H. Hand</u> Coroner			22b. ADDRESS <u>Clayton, Missouri</u>		22c. DATE SIGNED <u>11/22/63</u>
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11/22/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Leggs Chapel Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Aberdeen, Mississippi</u>		23e. STATE <u>Mississippi</u>		23f. COUNTY <u>Mississippi</u>	
24. FUNERAL DIRECTOR <u>Marion Office</u>		24a. ADDRESS <u>E. St. Louis, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>11-20-63</u>	
26. REGISTRAR'S SIGNATURE <u>John B. Mumfry</u>					

61110-045

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH
DIVISION OF PUBLIC HEALTH

11-1-48

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 Marion C. Officer

Licensed Embalmer No. 5177

P. O. Address St. Louis, Mo.

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.

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