

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Perk
Township Jackson
or
Village Carrollton
or
City _____ (No)

Ent'd
Registration District No. 700 File No. 21167
Primary Registration District No. 5929 Registered No. 23
St.: _____ Ward) _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME North M. Campbell

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>American</u>	SINGLE MARRIED <input checked="" type="checkbox"/> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH. <u>Sept 24 1857</u> (Month) (Day) (Year)		
AGE: <u>42 yrs 10 mos 02 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Farmer</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Springfield Mo</u>		
PARENTS	NAME OF FATHER <u>Wade Campbell</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't know</u>	
	MAIDEN NAME OF MOTHER <u>May Berry</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 26, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 24, 1910, to July 26, 1910, that I last saw him alive on July 26, 1910, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Typhoid Fever

3 Weeks (Duration) yrs. mos. ds.

Contributory _____
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) T. E. McBurne M. D.
July 27 - 1910 (Address) Walnut Grove

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence.

PLACE OF BURIAL OR REMOVAL Turkey Creek
DATE OF BURIAL July 27 - 1910
UNDERTAKER G. W. Brown
ADDRESS Walnut Grove

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. O. Campbell
(ADDRESS) Edgerton Kans
Filed 7-27 1910 REGISTRAR J. M. Laughlin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHILE PRINTING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine

PLACE OF DEATH

County.....
 Township..... Registration District No.....
 or.....
 Village..... Primary Registration District No.....
 or.....
 City..... (NO.....)
 City.....

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX..... COLOR OR RACE.....
 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH..... (Month)..... (Day)..... (Year).....
 AGE..... yrs..... mos..... ds.....
 IF LESS than 1 day,..... hrs. or..... min.?

OCCUPATION.....
 (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE.....
 (City or town, State or foreign country)

NAME OF FATHER.....

BIRTHPLACE OF FATHER.....
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER.....

BIRTHPLACE OF MOTHER.....
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant).....

(ADDRESS).....

Filed..... 19..... REGISTRAR

DATE OF DEATH.....
 I E.....
 that I last saw.....
 and that death.....
 The CAUSE.....

Contributory (SECONDARY)

(Signed).....

* State the means of injury

LENGTH OF RECENT RESIDENCE

At place of death.....

Where was died if not at place.....

Former or usual residence.....

PLACE OF BIRTH.....

UNDERTAKER.....

MI