

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

PLACE OF DEATH

County Rock
Township Green
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 708 File No. 11609
Primary Registration District No. 5937 Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ray E. Campbell

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OF RACE White SINGLE Married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH December 1858
(Month) (Day) (Year)

AGE 58 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS NAME OF FATHER Geo. Henninger
BIRTHPLACE OF FATHER (City or town, State or foreign country) Penn.
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) Wm. Garrison

(ADDRESS) Goodson Mo

Filed Mar 22 1911 W.F. Warren REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 19th 1911
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from Patient died before the doctor arrived. 1911, that I last saw him alive on _____, 1911, and that death occurred, on the date stated above 9:50 m.

The CAUSE OF DEATH* was as follows:
Probably Angina Pectoris - 30 minutes

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

(Signed) J.A. Lytle M. D. Mar 23rd 1911 (Address) Goodson

*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 Liberty Cemetery DATE OF BURIAL Mar 20th 1911

UNDERTAKER W.S. White ADDRESS Balsbar Mo

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, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *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 definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

County PolkTownship Green

Village _____

City _____ (NO. _____ St.; _____ Ward)

Registration District No. 708File No. 11609Primary Registration District No. 5937

Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ray G. Campbell

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)DATE OF BIRTH December, 1858
(Month) (Day) (Year)AGE 58 yrs. ___ mos. ___ ds. If LESS than 1 day, ___ hrs. or ___ min. ?OCCUPATION (a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) PennsylvaniaNAME OF FATHER Geo. DowningBIRTHPLACE OF FATHER (City or town, State or foreign country) Penn.MAIDEN NAME OF MOTHER Wm. BowmanBIRTHPLACE OF MOTHER (City or town, State or foreign country) Pa. Newn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Bowman(ADDRESS) Goodson Mo.Filed May 6th 1911 W. F. Warren REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 19th, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Patient died before the, 1911, that I last saw doctor arrived, 1911, and that death occurred, on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows:

Probably
Angina Pectoris(Duration) ___ yrs. 30 minutes

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

(Signed) J. A. Lytle M. D. March 23, 1911 (Address) Goodson

*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

Liperty Cemetery

DATE OF BURIAL

March 23 1911

UNDERTAKER

W. S. White

ADDRESS

Bolivar Mo.Original file, date Mar 22nd 1911

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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