

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.

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

PLACE OF DEATH
County Douglas
Township Camp bee
or Rosse
Village
or
City (NO. _____) St. _____ Ward _____

Registration District No. 281
Primary Registration District No. 538

File No. 17394
Registered No. _____

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

FULL NAME James Wright Camp bee

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH June 1, 1848
(Month) (Day) (Year)

AGE 62 yrs. 10 mos. 6 ds. If LESS than
1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER Isaac Campbell
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Elizabeth Wright
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Iowa

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Campbell
(ADDRESS) Iowa Mo.

Filed X 1911 _____
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 7, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 31, 1911, to Apr 7, 1911, that I last saw him alive on Apr 5, 1911, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
56 Heart Dropsy, complicated with rheumatism.
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) 141
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) W. J. Campbell M. D.
Apr 30, 1911 (Address) Iowa Mo.

*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 62 yrs. 10 mos. 6 ds. In the 62 yrs. 10 mos. 6 ds.
Where was disease contracted if not at place of death? at place of death
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Campbell Cemetery DATE OF BURIAL Apr 8, 1911
UNDERTAKER None ADDRESS Rome 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*, *Composer*, *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*, *peritonaeum*, 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.)



PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Douglas
 Township Campbell
 or
 Village _____
 or
 City _____

Registration District No. 281 File No. 17394
 Primary Registration District No. 5387 Registered No. _____
 (NO. _____ St. _____ Ward _____)

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

FULL NAME

James Wright Campbell.

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE married
 MARRIED
 WIDOWED
 OR DIVORCED
 (If file the word)
 DATE OF BIRTH June 1, 1848
 (Month) (Day) (Year)
 AGE 62 yrs. 10 mos. 6 ds.
 If LESS than 1 day, ____ hrs. or ____ min.

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

BIRTHPLACE
 (City or town, State or foreign country) Rome Mo

PARENTS

NAME OF FATHER Isaac Campbell
 BIRTHPLACE OF FATHER Virginia
 (City or town, State or foreign country)
 MAIDEN NAME OF MOTHER Elizabeth Wright
 BIRTHPLACE OF MOTHER Tenn.
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Campbell
 (ADDRESS) Ava Mo.

Filed May 4, 1911, by J. J. Bailey
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 7, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr. 1, 1911, to Apr 7, 1911,
 that I last saw him alive on Apr 5, 1911,
 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Heart Dropsy
complicated with rheumatism

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
 (SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. J. Campbell M. D.
Apr. 30, 1911 (Address) Ava Mo.

*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 62 yrs. 10 mos. 6 ds. In the State 62 yrs. 10 mos. 6 ds.
 Where was disease contracted if not at place of death? of death

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

Campbell Cemetery Apr. 8, 1911

UNDERTAKER

none

DATE OF BURIAL

ADDRESS

Rome Mo.

Original file, date May 4, 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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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.)