WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 Jasper

Township or Village or City Carthage (NO. Carthage Hospital Ward)

Registration District No. 408 File No. 26717

Primary Registration District No. 3020 Registered No. 103

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

FULL NAME Florence Campbell

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH March 7, 1884 (Month) (Day) (Year)

AGE 29 yrs. 4 mos. 22 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Home Tel. Co.

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

PARENTS

NAME OF FATHER John Edw Campbell

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

MAIDEN NAME OF MOTHER Nancy Murphy

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H. J. Kinsella

(ADDRESS) Carthage, Mo.

Filed Aug 8 1913 W E Steele REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 29, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 19, 1913, to July 29, 1913, that I last saw her alive on July 29, 1913, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Abscess of Appendix

1210

(Duration) ___ yrs. ___ mos. 10 ds.

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

(Signed) H. E. Baker M. D.

July 30, 1913 (Address) Carthage 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 ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence Carthage, Mo.

PLACE OF BURIAL OR REMOVAL Park Cemetery

DATE OF BURIAL Aug 3, 1913

UNDERTAKER Knell Und Co.

ADDRESS Carthage, Mo.

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

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

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

FULL NAME _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH _____, 1_____
(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)

PARENTS

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 _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
_____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

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

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

(Signed) _____ M. D.

_____, 191____ (Address) _____

*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	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS