

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

PLACE OF DEATH

County Madaway

Township _____

or

Village _____

or

City Manville (NO. _____) St.: _____ Ward _____

Registration District No. 625

File No. 32986

Primary Registration District No. 3031

Registered No. 95

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

FULL NAME Earl G Campbell

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Dec 13, 1883

(Month)

(Day)

(Year)

AGE 30 yrs. 9 mos. 20 ds.

If LESS than
1 day, ___ hrs.
or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Painter

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

BIRTHPLACE

(City or town, State or foreign country) Manville Mo.

NAME OF FATHER A M Campbell

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Indiana

MAIDEN NAME OF MOTHER Carolina Connor

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A M Campbell

(ADDRESS) Manville Mo.

Filed OCT 5 1914

J. B. Anthony

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 2, 1914

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from Sept 29, 1914, to Oct 3, 1914, that I last saw him alive on Oct 3, 1914,

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Juncos

54D

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

Contributory

(SECONDARY)

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

(Signed) F. M. Martin M. D.

Oct 5, 1914 (Address) Manville

*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

Miriam Cemetery

DATE OF BURIAL

Oct 5, 1914

UNDERTAKER

Pierce & McNeal

ADDRESS

Manville Mo.

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.

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, peritonaeum*, etc., *Carcinoma, Sarcoma*, 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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT MISSOURI STATE BOARD OF HEALTH
GIVE A FEE FOR CERTIFICATES BUREAU OF VITAL STATISTICS
UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CERTIFICATE OF DEATH

PLACE OF DEATH Wodaway
 County Wodaway Registration District No. 625 File No. _____
 Township _____ or _____
 Village Maryville Primary Registration District No. 3031 Registered No. 95
 City _____ (NO. _____) St. _____ Ward _____
 FULL NAME Earl G. Campbell [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) _____
 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
 AGE _____ yrs. _____ mos. _____ days 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 _____ 1914
 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 3 1914
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
 that I last saw him alive _____, 191____,
 and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:
Cerebral Tumor;
Non-Malignant
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory _____
 (Secondary) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) F. M. Mast
Oct 5 1914 (Address) Maryville
 *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 _____

SUPPLEMENTARY INFORMATION SUPPLIED

Revised United States Standard Certificate of Death

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

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