LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

File No. 8260

1 PLACE OF DEATH
County: Ozark
Township: Bayou
or
Village:
or
City: (NO. St.; Ward)

Registration District No. 647
Primary Registration District No. 5807
Registered No. 18

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

2 FULL NAME: Delmar E. Campbell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Apr. (Month) 25 (Day) 1914 (Year)

7 AGE: 5 yrs. 9 mos. 10 ds.
If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (City or town, State or foreign country): Wheeling, Ark.

PARENTS
10 NAME OF FATHER: Henry C. Campbell
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Wheeling, Ark.
12 MAIDEN NAME OF MOTHER: Zelah E. Ellison
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Baxter Co. Ark.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Henry C. Campbell
(Address): Bakersfield Mo.

15
Filed: Mch 9 1920 M. T. Price, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 5 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan. 27 1920, to Feb. 5, 1920, that I last saw him alive on Feb. 5, 1920, and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:
Influenza
11B 10
(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) M. A. Wiles M. D.
191.... (Address) Bakersfield, Mo.

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Williams Cemetery
DATE OF BURIAL: Feb. 6 1920
20 UNDERTAKER: John Stout
ADDRESS: Bakersfield Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 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.]

2 FULL NAME .....

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

3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day), 1..... (Year)

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

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191..... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day), 191..... (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191.....

20 UNDERTAKER | ADDRESS