AUG 23 1928

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

Do not use this space.

23523

1. PLACE OF DEATH
County: Greene
Registration District No.: 318
File No.: 23523
Township:
Primary Registration District No.: 2001
Registered No.: 498
City: Springfield (No. Springfield Baptist Hospital St. Ward)

2. FULL NAME: Clyde Joseph Campbell
(a) Residence. No. 1066 E Commercial St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 10-1927

7. AGE: Years 0 | Months 8 | Days 28 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child at Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: W. L. Campbell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Missouri Smith
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.

14. INFORMANT: W. L. Campbell
(Address) Springfield. Mo.

15. FILED 7-9, 1928 O C Horst Mo. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7 - 8 1928

17. I HEREBY CERTIFY, That I attended deceased from 7-4-, 1928, to 7-8, 1928 that I last saw h. alive on 7-8, 1928, and that death occurred, on the date stated above, at 2 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tumor of Brain
55D
(duration) yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Urban Busick, M. D
7/9, 1928 (Address) 401 St Louis St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bassville Cemetery DATE OF BURIAL: July 9 1928

20. UNDERTAKER: J. W. Klingner & Co. ADDRESS: 4046 E Coml Springfield. Mo.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2001 — Registered No. 498
City: Springfield (No. ..., St. ..., Ward)

2. FULL NAME: Clyde Joseph Campbell
(a) Residence. No. ... St., ... Ward. ...
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ... min.

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

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 7-9, 1928 — [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-8-1928

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tumor of Brain
Unknown if malignant
No operation
CONTRIBUTORY (SECONDARY) No Autopsy
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ..., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

THIS SPACE NOT RESERVED FOR THE PERSON WHO MUST SIGN THE CERTIFICATE AS PRESCRIBED

S-23523