

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

Do not use this space.

11754

1. PLACE OF DEATH

County Carroll Registration District No. 601
 Township Little River Primary Registration District No. 4388
 City Carthage No. _____ St. _____ Ward _____

File No. _____
 Registered No. 86

2. FULL NAME

Ada 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-18-1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 10 4 20

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Laborer
 (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) Ill.

10. NAME OF FATHER James M. Campbell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ill.

12. MAIDEN NAME OF MOTHER Julia Phillips

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill.

14. INFORMANT Mrs. Ada Campbell
 (Address) Carthage, Mo.

15. FILED Mar. 19, 1929 Ada Martin
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-17-1929

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 _____ p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Murdered by unknown parties by being beat on head with some blunt instrument (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Hemiplegia (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Ill.
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) P. Smith acting coroner

*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.
Mar. 17, 1929 (Address) Carthage, Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Carthage Cemetery DATE OF BURIAL 3-19-1929

20. UNDERTAKER A. J. Smith ADDRESS Carthage, 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.

APR 30 1929

237
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