

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

Do not use this space.

27 1929

15211
33

PLACE OF DEATH
County Jefferson
Township Wentworth
City St. Louis (No.)

Registration District No. 401
Primary Registration District No. 3024

File No. 33
Registered No.
St. Ward

2. FULL NAME

Thurmon 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female
4. COLOR OR RACE Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 25, 1866

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS THAN 1 DAY, IN HRS. OR MIN. |
|--------|-------|--------|------|-------------------------------------|
| | 62 | 3 | 15 | |

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

9. BIRTHPLACE (CITY OR TOWN) Wellington, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Jacob Hawkins

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Jackson Co. Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY)

14. INFORMANT Miss Leon Baldridge
(Address) Wellington, Mo.

15. April 11, 1929 G. W. Cope
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 10 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1928 to April 10, 1929 that I last saw her alive on April 7, 1929 at 7:15 p.m. and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pericarditis
109

(duration) 4 yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY) Lobar Pneumonia
(duration) 3 yrs. 3 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
At Home
IF NOT AT PLACE OF DEATH no

DID AN OPERATION PRECEDE DEATH? no DATE OF

WHAT TEST CONFIRMED DIAGNOSIS none
(Signed) J. D. Ball M. D.

April 11, 1929 (Address) Wellington, Mo.

*State the DISEASE CAUSING DEATH, or 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 Wellington, Mo. DATE OF BURIAL April 3, 1929

20. UNDERTAKER Wm. T. Geget ADDRESS Wellington, 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 Lopauette Registration District No. 461 File No. 33
 Township St. J. Primary Registration District No. 3024 Registered No. _____
 City Lexington (No. _____) St. _____ Ward _____

2. FULL NAME

Yennie 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 <u>F</u> | 4. COLOR OR RACE <u>Col</u> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid</u> |
|--------------------|--------------------------------|--|

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 _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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 July 19 1929 J. W. Cope REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 18 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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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