

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

Do not use this space.

19151

PLACE OF DEATH

County Ray
Township Richmond
City..... (No.....) St..... Ward.....

Registration District No. 744
Primary Registration District No. 5976B

File No.....
Registered No. 44
St..... Ward.....

2. FULL NAME John W. 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 (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs J.W. Campbell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5/19/1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 0 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(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) Ray Co Mo.

10. NAME OF FATHER James M. Campbell

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

12. MAIDEN NAME OF MOTHER Mahale Brown

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

14. INFORMANT Roy Campbell
(Address) Richmond Mo. R.F. D. 2

15. FILED May 21 1929 G. B. Day REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/19/29 19

17. I HEREBY CERTIFY, That I attended deceased from May 14 1929 to May 19 1929
that I last saw him alive on May 15 1929, and that death occurred, on the date stated above, at 6:29 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

876 Apoplexy
(duration) yrs. mos. 5 ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Home

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) L. B. Greene, M. D.

May 21 1929 (Address) Richmond Mo

*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

New Hope Cem 5/20/29 19

20. UNDERTAKER Chas. M. ... ADDRESS Richmond 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.

WRITE PLAINLY, WITH UNFADING INK IN THIS SPACE

JUN 27 1929

