

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

Do not use this space.

21666

File No. 15

Registered No. 15

1. PLACE OF DEATH

County Texas

Registration District No. 862

Township Boonville

Primary Registration District No. 6135

City Cabool (No. 4321)

St. _____ Ward _____

2. FULL NAME

James Madison Camp

(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 Stella Camp

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 20 1846

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
84 4 26

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

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

10. NAME OF FATHER William P. Camp

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Elmer Camp (Address) Boonville Mo.

15. June 16 1930 REGISTRAR A. N. Duvall

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 16 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1930 to June 16 1930 that I last saw him alive on Jan 15 1930 and that death occurred, on the date stated above, at 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic nephritis
Bright's Disease

131 (duration) 2 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 12/10 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Smears (Signed) _____ M. D.

June 16 1930 (Address) Cabool 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 Cabool Cemetery DATE OF BURIAL June 17 1930

20. UNDERTAKER Lawford V. Elliott ADDRESS Cabool

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 very important.

