

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

Do not use this space.

22649

PLACE OF DEATH

County Hickory
Township Tyler
City (No. _____) _____ St. _____ Ward _____

Registration District No. 1059
Primary Registration District No. 5310

File No. _____
Registered No. _____

2. FULL NAME Silas Andrew Smith 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 Ellen Campbell

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
27 11 12

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) Madison
(STATE OR COUNTRY) Indiana

10. NAME OF FATHER James Campbell

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

12. MAIDEN NAME OF MOTHER Burand

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

14. INFORMANT Ellen Campbell
(Address) Flamington MO

15. FILED 7 30, 19 1930 H. Marshall
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
15. DATE OF DEATH (MONTH, DAY AND YEAR) July-18- 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1929, 1929, to July 15, 1930
that I last saw him alive on July 17, 1930 and that death occurred, on the date stated above, at 11:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency

92 A

120 B

(duration) yrs. 6 mos. ds.

CONTRIBUTORY Chronic Arteritis
(SECONDARY)

(duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) A. S. Johnston M. D.

7-18, 1930 (Address) W. Beatland 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

Antioch Cem.

7-19- 1930

20. UNDERTAKER

ADDRESS

Hutcheson & Blue

Bolivar MO

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.

AUG 26 1930

Acta Importata

Acta Importata
Acta Importata
Acta Importata

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

ALL INFORMATION GIVEN FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Dicksony Registration District No. 103-2 File No.
 Township Nylea Primary Registration District No. 2-3-10 Registered No.
 City (No.) St. Ward)

2. FULL NAME Silas Andrew Smith 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-6-1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 11 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. da.
 (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)

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 9.16.1930

J. H. Marshall
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 18 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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