

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

Do not use this space.

39268

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.

JAN 19 1934

PLACE OF DEATH
 County Iron Registration District No. 1159
 Township Bellemead Iron Primary Registration District No. 8549
 City Bellemead (No.) St. Ward)

2. FULL NAME J. Sarah Catherine 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 8 / 1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
69 8 5

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

9. BIRTHPLACE (CITY OR TOWN) Bellemead
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Wm S. Striboden

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

12. MAIDEN NAME OF MOTHER Catherine Sheltor

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 20th 1933

17. HEREBY CERTIFY, That I attended deceased from Dec 18, 1933, to Dec 20th, 1933 that I last saw him alive on Dec 20th, 1933 and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
to congestion of lungs
118
1118

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Influenza
 (duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH at Place of death
 DID AN OPERATION PRECEDE DEATH? no DATE OF

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calcedonia Mo. DATE OF BURIAL Dec 1933
 WAS THERE AN AUTOPSY? no ADDRESS Iron Co. Mo.
 WHAT TEST CONFIRMED DIAGNOSIS? Physiain diagnosis
 (Signed) [Signature] M. D.
 19 (Address) Bellemead 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.

20. UNDERTAKER H. P. White & Son ADDRESS Iron Co. Mo.

14. INFORMANT Mrs. Alex Phillips
 (Address) Bellemead Mo.

15. FILED Jan 15 1934 Quais Byrman REGISTRAR

1930 - 12 - 20
69 - 8 - 5

1861 - 4 - 15

1930 - 12 - 20
1861 - 4 - 15
69 - 8 - 5

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Iron
Township 11 11
City (No.)

Registration District No. 115-9
Primary Registration District No. 3359

File No.
Registered No. 25
St. Ward

2. FULL NAME

Sarah Catherine 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 F 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) Oct 28 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 2 12

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)
(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 Jan 15 1931 Annice Berman REGISTRAR
By Mrs W C Townsend

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 20 19 30

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

Dec 20 19 30

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

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

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