

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.

APR 25 1931

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

Do not use this space.

17709

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 318
Township Springfield Primary Registration District No. 2001
City Springfield 720 Kearney St. Ward

File No. _____
Registered No. 410

2. FULL NAME

Peter Chas. Campbell
(a) Residence, No. 720 Kearney 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 colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 62

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Minister

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

13. NAME Peter Campbell

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

15. MAIDEN NAME Amanda Parno

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

17. INFORMANT (ADDRESS) Lillian Campbell Springfield Ark

18. BURIAL, CREMATION, OR REMOVAL PLACE Gurdon Ark DATE May 30 1931

19. UNDERTAKER (ADDRESS) W. P. Campbell 869 Washington Ave

20. FILED 5-29 1931 For Sharp Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-28-1931

22. I HEREBY CERTIFY, That I attended deceased from 4-19-1931, to 5-28-1931

I last saw him alive on 5-25-1931. Death is said to have occurred on the date stated above, at 3:20 a.m.

The principal cause of death and related causes of importance were as follows:

Obstinate Constipation
Septicæmia possibly
maligant
1695
11 12 30

Date of onset

Other contributory causes of importance:

(1)

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) C. J. Zeller, M. D.

(Address) Springfield Ark

E 4
4/16/41

U. S. - Every Item
OF DEATH

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS 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

1. PLACE OF DEATH.

County Registration District No. 318 File No.
 Township Primary Registration District No. 2001 Registered No. 4119
 City Springfield (No.) St. (Ward)

2. FULL NAME Peter Chas 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 e 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)

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
 (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)

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 5/24, 1931. Gen Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/28 1931

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abdominate Constipation
Autohaemia possibly
Malignant
 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) seat of malignancy not known
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? 460
 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

5-17709