

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 OCT 15 1934

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

Do not use this space
Dr. *W. E. Feller*
32536
#66

1. PLACE OF DEATH

County *Greene* Registration District No. *318*
Township _____ Primary Registration District No. *2891*
City *Springfield, Mo. 2701 W. Blvd*

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Self Washington Campbell
(a) Residence, No. *2701 W. Blvd, 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. da.

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 *Allie Campbell*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 14 1865*

7. AGE YEARS *69* MONTHS *6* DAYS *10* If LESS than 1 day, hrs. or min.

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

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) *Stratford Mo.*

13. NAME *Geo. Campbell*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*

15. MAIDEN NAME *Narcissis Bass*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

17. INFORMANT *Mrs. Allie Campbell* (ADDRESS) *2701 W. Blvd.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Springfield* DATE *Sept 26 1934*

19. UNDERTAKER (ADDRESS) *Springfield, Mo.*

20. FILED *9-15* 1934

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 24 1934*

22. I HEREBY CERTIFY, That I attended deceased from *9-10* 1934, to *9-24* 1934. I last saw her alive on *9-24* 1934. Death is said to have occurred on the date stated above, at *11:15 P.M.*

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

Septicemia followed Cancer of the Stomach
4 1/2 yrs

Other contributory causes of importance:

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) *G. E. Feller*, M. D. Address *Springfield, Mo.*

