

REC'D AUG 8 1938

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

24503
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 285
(b) Township Jackson Primary Registration District No. 1002
(c) City Jackson City (d) Street No. 725 Gen Hosp Registered No. 3008
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

William Young Campbell 514
(a) Residence, No. 1001 Penn St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-25-1876

7. AGE YEARS 69 MONTHS / DAYS / IF LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None

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

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 12

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

13. NAME Wm. Campbell

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

15. MAIDEN NAME Celesta Davis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky John Campbell

17. INFORMANT (ADDRESS) Dr. J. C. Foster 10101 East

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE July 30 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C. J. Foster 915 Brooklyn

20. FILED July 27 1938 M. M. Osborne Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-26 1938

22. I HEREBY CERTIFY, That I attended deceased from 7-23 1938 to 7-26 1938

I last saw him alive on 7-26 1938 Death is said to have occurred on the date stated above, at 10:20 PM

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

Chronic vasculorhe- phritis; Chronic enterocelitis

Date of onset

Other contributory causes of importance: Chronic venema

Name of operation Date of Was there an autopsy? Yes

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 Yes

(Signed) Dr. J. C. Foster M. D.

(Address) East Dept 725 Gen Hosp

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,,
....., or by,
Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.