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

APR 21

1. PLACE OF DEATH
County Vernon 2 Registration District No. 876 File No. 12627
Township 1 Primary Registration District No. 4529 Registered No.
City Richards (No. St. Ward)

2. FULL NAME Thaddeus Campbell
(a) Residence. No. St. Ward. (If nonresident give city or town and State)
(Usual place of abode)
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 Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 7 1853

7. AGE Years 85 Months 5 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) W.O.R.G. Ry Co.
(c) Name of employer W.O.R.G. Ry Co.

9. BIRTHPLACE (CITY OR TOWN) Circleville 1
(STATE OR COUNTRY) Ohio 9

PARENTS
10. NAME OF FATHER Bout know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bout know
(STATE OR COUNTRY) Bout know
12. MAIDEN NAME OF MOTHER Bout know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bout know
(STATE OR COUNTRY) Bout know

14. INFORMANT Amanda Hopf
(Address) Richards Mo. 72

15. FILED 3-22, 1939 Stella Field REGISTRAR
794

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mch 5 1939

17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1939, to Mch 4, 1939 that I last saw him alive on Mch 4, 1939, and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis 93C

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) General arteriosclerosis

(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? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) L. E. Kilmer, M.D.
, 19 (Address) Fort Scott Kansas

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maplehurst Cem.
DATE OF BURIAL 3-6 1939

20. UNDERTAKER O. W. Cheney
ADDRESS Fort Scott Ks

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.

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

District Health Officer No. 1-8
District File Number 7-39-528
Date Filed 4-14-39

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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.