

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

**15201**  
 Do not use this space.

REC'D MAY 19 1939

**1. PLACE OF DEATH**

(a) County Joplin Registration District No. 417  
 (b) Township Joplin Primary Registration District No. 3021 Registered No. 39  
 (c) City Joplin or (d) Street No. 1405 BROADWAY St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. 7 ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME** Tommy Campbell

(a) Residence, No. 1405 Broadway 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>	
		5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>Pauline Campbell</u>	
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 29, 1903</u>			
7. AGE	YEARS <u>35</u>	MONTHS <u>11</u>	DAYS <u>20</u>
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Painter</u>		
	9. Industry or business in which work was done, as 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) <u>Missouri</u>			
FATHER	13. NAME <u>William Campbell</u>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>		
MOTHER	15. MAIDEN NAME <u>Fannie Walden</u>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Texas</u>		
17. INFORMANT (ADDRESS) <u>(Mother) Fannie Critchard</u> <u>Castroville, Mo.</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Oak Hill Cem.</u> DATE <u>April 25, 1939</u>			
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>W. H. Schexnayder</u> <u>Kath City, Mo.</u>			
20. FILED APR. 25, 39, 19 <u>W. H. Schexnayder</u> Local Registrar.			

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from 4-16-39 to 4-19-39  
 I last saw him alive on 4-19-39 Death is said to have occurred on the date stated above, at 6:50 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Pulmonary Tuberculosis

Other contributory causes of importance: 23-

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) W. H. Schexnayder, M. D.  
 299 (Address) Castroville, Mo.

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.

RECEIVED

District Health Officer No. 6,

District File Number 6-5-39-1019

Date Filed MAY 2 1939

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.....

*E. M. Hedge*

Registered Apprentice No.....

working under my personal supervision.

Signed *E. M. Hedge*

Licensed Embalmer No. 3857

P. O. Address New City

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

15201  
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 417  
 (b) Township Clayton Primary Registration District No. 3021  
 (c) City Webb City (d) Street No. 1405 BROADWAY St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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

(a) Residence, No. 1405 Broadway St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 19 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said

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

I last saw h... alive on ... 19... Death is said to have occurred on the date stated above, at ... m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.  
35 11 20

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

Pulmonary Tuberculosis  
 Date of onset

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

Other contributory causes of importance:

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED MAY 24 1939

A. H. Gregory  
 Local Registrar

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) A. H. Gregory D.O.

(Address) Webb City Mo

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

Every register information must 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.

