

SEP 6 1939

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

28100

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Jean Primary Registration District No. 1012
(c) City Jackson City (d) Street No. 3424 Wayne 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.

Registered No. 3102

2. PRINT FULL NAME

514 Charles J. Campbell
(a) Residence, No. 3429 Wayne St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (use the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 23 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 8 10

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

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

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 7

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adair Falls Iowa

FATHER 13. NAME Robt H. Campbell

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

MOTHER 15. MAIDEN NAME Matilda Cropper

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

17. INFORMANT (ADDRESS) Kathryn Campbell widow 3429 Wayne

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Green Valley 8/5/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Melody Wiley 8th and S. Mo

20. FILED 8-4-39 mmg Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-3 1939

22. HEREBY CERTIFY, That I attended deceased from Aug 1937, to Aug 3 1939

I last saw Aug alive on 8-1 1939 Death is said

to have occurred on the date stated above, at m.

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

Apoplexy; Generalized Arteriosclerosis

Arteriosclerotic Heart Disease

Other contributory causes of importance: None

Name of operation: _____ Date of: _____

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

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) O. De Maria M. D.

(Address) Sanitarium Hospital

(Licensed Embalmer's Statement on Reverse Side)

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.

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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.