

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

7626
 Do not use this space.

1. PLACE OF DEATH *Temiscal* *V* Registration District No. *65-1*
 (a) County *Temiscal* 0 Primary Registration District No. *4388*
 (b) Township *Caruthersville* (f) How long in U. S., if of foreign birth? yrs. mos. da.
 (c) City *Caruthersville* (d) Street No. _____ 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *Fanny Lee Campbell*
 (a) Residence, No. *E. 14th St.* 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 *Female* 4. COLOR OR RACE *Black* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 26, 1939*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 8 0

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Infant*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Infant*
 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) *Parteageville, Mo.*

FATHER
 13. NAME *Cliff Campbell*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Duck Hill, Miss.*

MOTHER
 15. MAIDEN NAME *Willie May Crawford*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Jackson, Miss.*

17. INFORMANT (ADDRESS) *Cliff Campbell, Caruthersville, Mo.*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Caruthersville, Mo.* DATE *Jan. 27, 1940*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Friends, Caruthersville, Mo.*
 20. FILED *Jan. 26, 1940* *Ada Martin* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan. 26, 1940*
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h_____ alive on _____, 19____. 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:
Whooping cough
Pharyngitis
 Date of onset _____

Other contributory causes of importance:
Bacterial Pneumonia

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? *no*

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. P. Phipps, Health Officer* M. D.
 (Address) *Caruthersville*

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.

32-2-110

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.