

FILED JUL 15 1940

Registration District No. 883

Primary Registration District No. 4226

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Haskell
(b) City or town Mountain View Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 74 years
years, months or days

3. (a) PRINT FULL NAME Rosa A Campbell

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife R.H. Campbell 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased July 13 1865
(Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days 5
If less than one day hr. _____ min. _____

9. Birthplace North Carolina
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

12. Name Andy Fouts

18. Birthplace North Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Elyzabeth Davis

15. Birthplace North Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant R.H. Campbell

(b) Address Mountain View Mo.

17. (a) Burial (b) Date thereof June 19-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Delgrin Rest

18. (a) Signature of funeral director John F. Reinecke

(b) Address Mountain View Mo.

19. (a) _____ (b) W.W. Cotttingham
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Haskell
(c) City or town Mountain View Mo
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18th
year 1940 hour 6 minute 9 M.

21. I hereby certify that I attended the deceased from just over
call - 6/17/40 to _____, 19____
that I last saw her alive on June 17, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia
following
Due to cerebral hemorrhage

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 343

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature W.W. Cotttingham (M. D. or other) 343
Address Mountain View Mo. Date signed 6/19/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

822

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21885-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 383

Primary Registration District No. 4226

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Hovell
(b) City or town Mountain View Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Rosa A Campbell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

INTERNATIONAL CERTIFICATION

20. DATE OF DEATH: Month June day 18 year 1970 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia following cerebral hemorrhage

Due to: Bronchial pneumonia

Due to: Senility - hardening of arteries + Hypertension.

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature W. H. Attingham (M. D. or other) _____

Address Not given Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

