

No. 2
1-13-40
17-39
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FILED AUG 9 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25257

State File No. _____
Registrar's No. 628

Registration District No. 316

Primary Registration District No. 5440

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

1. PLACE OF DEATH: GREENE S. Campbell
(a) County _____
(b) City or town Springfield
(c) Name of hospital or institution: Medical Center for Federal Prisoners 3
(d) Length of stay: In hospital or institution 2 yr. 11 mo. 13 da
In this community 2 yrs., 11 mos., 13 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Car. (b) County Guilford
(c) City or town Greensboro
(d) Street No. Bessemer Branch Post Office
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME HORNEY, William Leo 65U
(b) If veteran, name war None
(c) Social Security No. na

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 28
year 1940 hour 11 minute 30 P.A.M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 25, 1915
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug. 14, 1937, 19____ to July 28, 1940, 19____; that I last saw him alive on July 28, 1940, 19____ and that death occurred on the date and hour stated above.

8. AGE: Years 24 Months 7 Days 3 If less than one day _____ hr. _____ min.

Immediate cause of death
Death by Hanging (Suffocation)
Due to _____
Due to _____

9. Birthplace Greensboro N. Car. /
(City, town, or county) (State or foreign country)

Other conditions Dementia Praecox
(Include pregnancy within 3 months of death)

10. Usual occupation Grocery Store Manager
11. Industry or business Pender's Chain Store

PHYSICIAN
Major findings:
Of operations _____
Of autopsy Aphyxia 116
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name C. D. Horney
13. Birthplace Unknown N. Car. /
(City, town, or county) (State or foreign country)
14. Maiden name Rosalie Smith
15. Birthplace Unknown N. Car. /
(City, town, or county) (State or foreign country)
16. (a) Informant Deceased
(b) Address _____

17. (a) Removal (b) Date thereof July 30-40
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Suicide
(b) Date of occurrence July 28, 1940.

(c) Place: burial or cremation Greensboro N. Car. /
(d) Signature of funeral director _____
(e) Address _____
(f) Date received at local registrar July 30, 1940 W. E. Handley M.D.
(g) Registrar's signature _____
(h) Address _____

(c) Where did injury occur? Springfield, Greene, Missouri
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Med. Center for Federal Prisoners (Hosp.)
While at work? No (Specify type of place) (e) Means of injury _____
(f) Signature _____ (M. D. or other) _____
(g) Address _____ Date signed 7/30/40

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, fact should be so stated above.

