

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 693

1. PLACE OF DEATH Greene  
 (a) County Greene  
 (b) City or town Springfield  
 (c) Name of hospital or institution City Hospital  
 (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 111

3. (a) PRINT FULL NAME MARY ANN CAMPBELL

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased October 19 1938  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>10</u>	<u>4</u>	hr. _____ min. _____

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

10. Usual occupation Wid

11. Industry or business \_\_\_\_\_

12. Name S. Frank Campbell

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

14. Maiden name W. Paul Wolf

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

16. (a) Informant S. Frank Campbell

(b) Address 1211 N. Warren

17. (a) Burial (b) Date thereof Aug 25-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director J. W. Klingner & Co.

(b) Address Springfield Mo

19. (a) Aug 25, 1940 (b) W. E. Handley  
(Date received at registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Greene  
 (c) City or town Springfield  
 (If outside city or town limit, write "RURAL")  
 (d) Street No. 1211 N. Warren  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Aug day 23 year 1940 hour 2:10 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Aug 20, 1940, to Aug 23, 1940 that I last saw her alive on Aug 23, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Stomach & dehydration Duration months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions antimemori  
(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? at home

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

Signature W. Roland (M. D. or other)

Address Springfield Mo Date signed 8/26/40

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

MOTHER, FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

1881  
66

**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 William Gray Thoburn

Licensed Embalmer No. 407

P. O. Address Springfield

**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. **28536-**  
Registrar's No. **693**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **318**

Primary Registration District No. **2001**

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

1. PLACE OF DEATH:

(a) County **Greene**  
(b) City or town **Springfield**  
(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 **Mary Ann Campbell**

3. (b) If veteran name was..... 3. (c) Social Security No.....

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

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

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

8. AGE: Years Months Days If less than one day  
**1 10 4** hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) **10-14-40** (b) **W.E. Handley MD**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **23**  
year **1940** 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 **Starvation**  
**and Dehydration**  
**(dietary deficiency from**  
**pet milk + water formula)**

Due to.....  
Due to.....

Other conditions..... (Include pregnancy within 3 months of death) **156**

Major findings:  
Of operations.....  
Of autopsy.....

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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 play) (e) Means of injury.....

23. Signature **W. Poland Langston MD** of other.....  
Address **Springfield Mo** Date signed.....

SUPPLEMENTARY

