

FILED OCT 18 1940

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

32879
Do not use this space.

1. PLACE OF DEATH

(a) County Wife Registration District No. 687
(b) Township Prairieville Primary Registration District No. 5915 Registered No. _____
(c) City _____ (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Edward P. Campbell

(a) Residence, No. _____ 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 26 - 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 2 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
9. Industry or business in which work was done, as saw mill, bank, etc. _____
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) Va.

FATHER 13. NAME John Campbell

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

MOTHER 15. MAIDEN NAME Eliza Schoder

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

17. INFORMANT (ADDRESS) E. C. Steinhage
Clarksville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Corinth DATE Oct-15-1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gooch & Davis Co.
Clarksville Mo

20. FILED Sept. 30 1940 W. M. Gooch
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____ 19 _____

22. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1940 to Sept 29, 1940.
I last saw him alive on Sept 29, 1940. Death is said to have occurred on the date stated above, at 9:15 A.M.
The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage
arterio-sclerosis and high blood pressure
Date of onset 9/29/40
Other contributory causes of importance: arterio-sclerosis and high blood pressure
2nd

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? no
If so, specify _____
(Signed) E. M. Bonifant M. D.
(Address) Clarksville Missouri

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.

RECEIVED

District Health Officer No. 10

District File Number 16-40-1897

Date Filed OCT 9 1940

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

Norman E. Gooch

Licensed Embalmer No. 2342

P. O. Address

Eolis, Mo.

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. 32879

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 687

Primary Registration District No. 5915

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Prairieville 78
(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)

3. (a) PRINT FULL NAME Edw F Campbell

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

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

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 74 Months 2 Days 3 If less than one day _____ 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) _____ (b) B.M. Gooch (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike

(c) City or town Rural
(If outside city or town limits write "RURAL")

(d) Street No. R.F. W. - 1st
(If rural, give postal address)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29 year _____ 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 _____

Due to _____

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? _____

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

23. Signature E. M. Barefoot (M. D. or other) _____

Address Charlottesville Va Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

271

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