

Registration District No. **598**

Primary Registration District No. **4355 703**

Registrar's No. **23**

1. PLACE OF DEATH:

(a) County Morgan
(b) City or town Morgan
(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

3. (a) PRINT FULL NAME Lera Mae Campbell

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

4. Sex Female 5. Color of 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 Nov 29 1939
(Month) (Day) (Year)

8. AGE: Years _____ Months 4 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Luther Campbell

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

14. Maiden name Ella Howard

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

16. (a) Informant's own signature Luther Campbell

(b) Address Versailles, Missouri

17. (a) Burial (b) Date thereof Apr 8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Thornwell Cemetery

18. (a) Signature of funeral director W. T. Kidwell

(b) Address Versailles, Missouri

19. (a) 5-10-40 (b) Will F. Perry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month April day 7
year 1940 hour 2 minute _____ P. A. M.

21. I hereby certify that I attended the deceased from Apr 6 1940, to Apr 7 1940
that I last saw her alive on Apr 7 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 4 days

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? 640

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

23. Signature A. J. Gunn (M. D. or other) _____

Address Versailles, Mo Date signed 4-8-40

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.

107a

RECEIVED

District Health Officer No. 4;

District File Number 12-40-1677

Date Filed 12-3-40

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39-323
Registrar's No. _____

Registration District No. 298

Primary Registration District No. 5792

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

1. PLACE OF DEATH:

(a) County Morgan
(b) City or town Morgan Twp.
(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 _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Rural (b) County Morgan
(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

Lora Mae Campbell

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
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
4 8 _____ 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 7 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 Broncho pneumonia

Due to Whooping Cough - Croup

Due to _____
Other conditions none
(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 A J Gunn (M. D. or other)

Address Urbana Mo Date signed 4-29-70

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

SUPPLEMENTARY

S-39323 1940