

Registration District No. 632254

Primary Registration District No. 5834-5867

Registrar's No. ....

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

5  
00

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Thayer (Rural) Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 2 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Oregon 75

(c) City or town. 0  
(If outside city or town limits, write "RURAL")

(d) Street No. .... (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country. 0

3. (a) PRINT FULL NAME Ruthie Mary Campbell

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month February day 19 year 1942 hour 8 minute 00 P. M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife. William E. Campbell 6. (c) Age of husband or wife if alive. years 19 (Day) 1862 (Year)

7. Birth date of deceased. July (Month) 19 (Day) 1862 (Year)

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw h. alive on and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>7</u>	<u>--</u>	hr. <u>min.</u>

Immediate cause of death Cardiac Arrest  
hypertensive heart disease  
renal arteriosclerosis

Due to renal arteriosclerosis

Due to renal arteriosclerosis

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

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

Major findings: gsc  
Of operations. ✓

Of autopsy. ....

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

10. Usual occupation. Housewife

11. Industry or business

12. Name James A. Clark

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

14. Maiden name Carter

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

16. (a) Informant Oliver Campbell  
(b) Address Koshkonong Missouri

17. (a) Burial (b) Date thereof. Feb. 27 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Koshkonong Cemetery

18. (a) Signature of funeral director. Rev. Carr

(b) Address Thayer Missouri

19. (a) 2-7-42 (b) Joe D. Williams  
(Date received local registrar) (Registrar's signature)

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 0

23. Signature Joe D. Williams (M. D. or other) MD

Address Thayer Missouri Date signed 2-3-42

RECEIVED

District Health Officer No. 5

District File Number

742463

Date Filed

8-6-42

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 24920

Registration District No. 254

Primary Registration District No. 5867

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Oregon  
(b) City or town Rural  
(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 2 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Oregon  
(c) City or town Thayer Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. None (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ruthie Mary Campbell

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

4. Sex F 5. Color or race \_\_\_\_\_ 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 July 19 1942  
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days \_\_\_\_\_ If less than one day  
\_\_\_\_\_ min.

9. Birthplace La.  
(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 \_\_\_\_\_  
(Burial, cremation, or removal) (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 July Day \_\_\_\_\_ Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her 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 \_\_\_\_\_

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

