

FILED JAN 12 1944

Registration District No.

Primary Registration District No. 1005

Registrar's No. 1374

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution: Mo. Methodist Hosp. St. Joseph
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Della Campbell

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

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife no record 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug. 5 1868 (Month) (Day) (Year)

8. AGE: Years 45 Months 4 Days 17 If less than one day hr. min.

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

10. Usual occupation CARPENTER

11. Industry or business JOHN CAMPBELL

12. Name JOHN CAMPBELL 13. Birthplace Ia. (City, town, or county) (State or foreign country)

14. Maiden name MARGARET ROWLAND 15. Birthplace OHIO (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Green Sunnood

(b) Address KANSAS CITY - MO

17. (a) BURIAL (b) Date thereof 12-26-43 (Month) (Day) (Year)

(c) Place: burial or cremation LATHROP MO.

18. (a) Signature of funeral director DEMOSS CRUNK

(b) Address LATHROP MO.

19. (a) 12-26-43 (b) Rose Heyog (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Buchanan
(c) City or town St. Joseph
(d) Street No. no record
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 22 year 1943 hour 11:30 P. M. minute M.

21. I hereby certify that I attended the deceased from Dec. 18 to Dec. 22, 1943, to Dec. 22, 1943

that I last saw him alive on December 22, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Heart Disease / Arteriosclerosis

Due to Arteriosclerosis, general

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 W. Campbell (M. D. or other)

Address St. Joseph, Mo. Date signed 12-25-43

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____

working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Licensed Embalmer No. 2583

P. O. Address Lehigh 110

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution mo. Methodist Hosp
(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 Hell 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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Aug. 5
(Month) (Day) (Year)
8. AGE: Years 75 Months 4 Days _____ If less than one day _____ min.

9. Birthplace Ill
(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) _____
(Data received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH: Month Dec day 13 year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 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 Heart disease
arteriosclerosis
Ch. Myocarditis
Due to arteriosclerosis
General
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: 93d
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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

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

5-41565