

No. 42  
-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43359**

FILED JAN 19 1944  
Registration District No. **322**

Primary Registration District No. **3071**

Registrar's No. **24**

1. PLACE OF DEATH:  
(a) County **Saline**  
(b) City or town **Slater**  
(c) Name of hospital or institution: **none**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **none**  
In this community **all his life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **Saline**  
(c) City or town **Slater**  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME **Daniel Pierce Cameron**  
(b) If veteran, name war **no**  
(c) Social Security No. **no**

MEDICAL CERTIFICATION  
20. DATE OF DEATH, Month **Dec.** day **15th**  
year **1943** hour **8** minute **P.** M.

4. Sex **male**  
5. Color or race **white**  
6. (a) Single, widowed, married, divorced, **widowed**  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **July 15 1852**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1942** 19 \_\_\_\_\_ to **Dec - 15 - 1943** 1943  
that I last saw him alive on **Dec - 10 - 1943** 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**91 7** hr. \_\_\_\_\_ min.

Immediate cause of death **uræmia**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation **farmer**

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

MOTHER FATHER  
12. Name **Howard Cameron**  
13. Birthplace **Tenn**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Nancy Thornton**  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant **R. C. Cameron,**  
(b) Address **Slater, Mo.**

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 \_\_\_\_\_

17. (a) **burial** (b) Date thereof **12-17-'43**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Slater, Mo.**  
**Hill Brothers,**  
18. (a) Signature of funeral director **Slater, Mo.**  
(b) Address \_\_\_\_\_  
19. (a) **1-5-44** (b) **Mrs. John Giger**  
(Date received local registrar) (Registrar's signature)

23. Signature **M. C. Deppie** (M. D. or other)  
Address **Slater, Mo.** Date signed **12/15/43**

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

1-7-44

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 \_\_\_\_\_

A. C. Hill

Licensed Embalmer No. \_\_\_\_\_

3090

P. O. Address \_\_\_\_\_

State - 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, 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. \_\_\_\_\_

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

**1. PLACE OF DEATH:**  
 (a) County *Saline*  
 (b) City or town *Saline*  
(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 years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)  
**3. (a) PRINT FULL NAME** *David P. Cameron*  
 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 *W*  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year  
 7. Birth date of deceased *July 15, 1909*  
(Month) (Day) (Year)

8. AGE: Years *91* Months \_\_\_\_\_ Days \_\_\_\_\_ (Less than one day)  
 or \_\_\_\_\_ 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 \_\_\_\_\_  
(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)

**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 \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month *Dec* Day *25*  
 year *1943* hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 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 *Acute nephritis*  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: *12/25*  
 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. Praggins* (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

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

S-43899