

FILED APR 19 1945

Registration District No. 2-2-3

Primary Registration District No. 3074

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

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

1950

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston  
(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 5092 years, months or days

3. (a) PRINT FULL NAME JAMES BENTON CAMPBELL

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Aloia 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 30 1863  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>1</u>	<u>9</u>	hr. min.

9. Birthplace Booneville Ind  
(City, town, or county) (State or foreign country)

10. Usual occupation Mercantile

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

12. Name James Campbell

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

14. Maiden name Mattie Kelly

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

16. (a) Informant Mrs Effie Campbell  
(b) Address Sikeston Mo

17. (a) Burial (b) Date thereof 1-10-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Welch Funeral Home  
(b) Address Sikeston Mo.

19. (a) 4/7/45 (b) Levie Largent  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott

(c) City or town Sikeston Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. 728 N. Ranney  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9  
year 45 hour 11 minute 00 P. M.

21. I hereby certify that I attended the deceased from Sept 1942 to Jan 9 1945  
that I last saw him alive on Jan 7 1945,  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to apoplexy

Due to General Arterio sclerosis

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy 930

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? \_\_\_\_\_  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury 0

23. Signature Howard M. Lind (M. D. or other) \_\_\_\_\_  
Address Sikeston Mo. Date signed 1-17-45

Duration 2 yrs

4 mos

10 yrs

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 445-801

Date Filed 7/14/45

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 *Raymond Crews*  
Licensed Embalmer No. *3467*  
P. O. Address *Sikeston 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.