. S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

23458

State File No.

FILED AUG 3 1945

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 795

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: State Hospital #2 St Joseph Mo. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months (Specify whether

In this community 3 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County North 11

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

(d) Street No. None (If rural, give location) 7

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME BENJAMIN ESTA CAMPBELL

3. (b) If veteran, name war No facts

3. (c) Social Security No. None

4. Sex M. O

5. Color or race WHITE

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

6. (b) Name of husband or wife Cornelia Campbell

6. (c) Age of husband or wife if alive No facts years

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years 80 Months No facts Days If less than one day ✓ hr. ✓ min.

9. Birthplace No facts (City, town, or county) U.S.A. (State or foreign country)

10. Usual occupation No facts

11. Industry or business No facts

FATHER
12. Name No facts
13. Birthplace No facts (City, town, or county) A (State or foreign country)

MOTHER
14. Maiden name No facts
15. Birthplace No facts (City, town, or county) A (State or foreign country)

16. (a) Informant None

(b) Address ✓

17. (a) removal (Burial, cremation, or removal) (b) Date thereof July 22 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Grant City Mo.

18. (a) Signature of funeral director Heaton Be Gole + Bowman

(b) Address St Joseph Mo.

19. (a) 7-21-45 (Date received local registrar) (b) Helen L. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1945 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from July 19, 1945, to July 21, 1945 that I last saw him alive on July 21, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis	No facts
Due to: Arteriosclerosis	
Senility	
Due to	
Other conditions: None (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

9320

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature George M. Boteler (M. D. or other)

Address St Joseph Mo. Date signed 7/21/45

1377

(Licensed Embalmer's Statement on Reverse Side)

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 Gerald T. Wade

Licensed Embalmer No. 49-72

P. O. Address St. Joseph

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.