

S. No. 2  
OM-2-43  
v. 5-17-39  
I X35897

24211

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 6 1945

Registration District No. 126

Primary Registration District No. 2001

Registrar's No. 330

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Dr. R. P. Loney

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: St. Johns Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 mos  
(Specify whether in this community years, months or days) most of lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

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

(d) Street No. 604 N. High St  
(If rural, give location)

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

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

3. (a) PRINT FULL NAME Ross C Campbell

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20  
year 1945 hour 8 minute 20 P. M.

4. Sex MO 5. Color or race W

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Pearl 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased: October 16 1895  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 10 1944 to July 20 1945  
that I last saw him alive on July 20 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years 49 Months 9 Days 4 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death exhaustion Duration 18 mos

Due to neuro-fibroma of mesentery

9. Birthplace Cape Girardeau MO  
(City, town, or county) (State or foreign country)

Other conditions 1  
(Includes pregnancy within 3 months of death)

10. Usual occupation Pharmacist

Major findings: Of operations 562

Of autopsy \_\_\_\_\_

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

11. Industry or business Pharmacist

12. Name James Campbell

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

14. Maiden name Anna Brown

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

16. (a) Informant Mrs Ross C. Campbell

(b) Address 604 N. High St

17. (a) Burial (b) Date thereof 7-23-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Memorial

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? \_\_\_\_\_

18. (a) Signature of funeral director Pharmacist

(b) Address 305 W. 4th St

19. (a) 7-23-45 (b) Arthur S. Suda  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

Signature R. P. Loney (M. D. or other) \_\_\_\_\_  
Address Jasper, Mo Date signed 7/23/45

PRO 4 (Licensed Embalmer's Statement on Reverse Side)

45-7-597

AUG 10 1945

AUG 7 1945

AUG 8 1945

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 Paul A. Lambill

Licensed Embalmer No. 3590

P. O. Address Spencer, Md

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.