

FILED JUL 17 1945

Registration District No. 254

Primary Registration District No. 5865

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon (Gale) Couch
(b) City or town Thayer Thayer Twp.
(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 25 years
years, months or days

3. (a) PRINT FULL NAME Laura Minervia Campbell

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Willis W. Campbell 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Dec. 14 1883
(Month) (Day) (Year)

8. AGE: Years 61 Months 4 Days 13 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name John Davis
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Ellen Tackett
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant W. W. Campbell
(b) Address Thayer, Mo.

17. (a) Burial (b) Date thereof 4/28/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jeff Cem.

18. (a) Signature of funeral director Res Parr

(b) Address Thayer, Mo.

19. (a) 6-15-45 (b) Gae W. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon

(c) City or town Thayer (Rural)
(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 April day 27
year 1945 hour 10 minute 40 A.M.

21. I hereby certify that I attended the deceased from July 1944 to April 27, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Colon

Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external injury, 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 D.W. Cooper (M. D. or other) MD

Address Thayer, Mo. Date signed 5-21-45

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

RECEIVED

District Health Officer No. 5,

District File Number 745-345

Date Filed 7-16-45

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.....

Licensed Embalmer No.

P. O. Address.....

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.