S. No. 2
M—5-43
. 5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27888

Registration District No. 20-1 Primary Registration District No. 3043 Registrar's No. 178

1. PLACE OF DEATH:

(a) County: Marion

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

(c) Name of hospital or institution: Levering Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 16 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Shelby

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: JASPER MARION CAMPBELL

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Male O

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Kittie Campbell

6. (c) Age of husband or wife if alive: ✓ years

7. Birth date of deceased: Oct. (Month) 9 (Day) 1862 (Year)

8. AGE:

Years	Months	Days	If less than one day
82	8	16	✓ hr. ✓ min.

9. Birthplace: Shelby Co. (City, town, or county) Mo. O (State or foreign country)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: John Campbell
13. Birthplace: no record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: no record
15. Birthplace: no record (City, town, or county) (State or foreign country)

16. (a) Informant: John G. Campbell
(b) Address: Shelbyville, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 27-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Shelbyville, Mo.

18. (a) Signature of funeral director: Wm. M. Lynch
(b) Address: Hannibal Mo.

19. (a) 6/25/45 (Date received by local registrar) (b) Eve M. Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25 year 1945 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from June 10, 1945 to June 25 1945 that I last saw him alive on June 24 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Arterio sclerosis

Due to: Senility

Due to:

Other conditions: no
(Include pregnancy within 3 months of death)

Major findings:
Of operations: no

Of autopsy: G.T.

Duration

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: O

23. Signature: J. H. Hardesty M.D. (M.D. or other)

Address: Hannibal Mo Date signed 6-25-45

1398

(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 C. L. Fuland

Licensed Embalmer No. 1399

P. O. Address Hannibal 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.