

FILED AUG 19 1946

Registration District No. 528

Primary Registration District No. 3073

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Chaffee  
(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 25 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott / 100  
(c) City or town Chaffee 1  
(If outside city or town limits, write "RURAL")  
(d) Street No. 316 N Third St 1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26  
year 1946 hour 7:45 minute 5 P.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death: Heart Failure  
Due to Chronic Bronchitis

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

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

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? \_\_\_\_\_

18. (a) Signature of funeral director Displinghoff Funeral Home  
(b) Address Chaffee Mo.  
23. Signature Arthur Taylor  
Address Director Mo Date signed 7/20/46

3. (a) PRINT FULL NAME Wahace Warren Campbell

3. (b) If veteran, name war ✓ 3. (c) Social Security No. 489-18-4994

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

6. (b) Name of husband or wife Emma Penning Campbell 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased March 4, 1869  
(Month) (Day) (Year)

8. AGE: Years 77 Months 4 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation laborer

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

MOTHER FATHER { 12. Name James S Campbell  
13. Birthplace Anna Ill  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Statter  
15. Birthplace Anna Ill  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr Emma Campbell  
(b) Address Chaffee Mo

17. (a) Burial (b) Date thereof 7-31-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Park Chaffee Mo

18. (a) Signature of funeral director Displinghoff Funeral Home  
(b) Address Chaffee Mo.

19. (a) Aug 8 46 (b) G.B. MacCreedy  
(Date received local registrar) (Registrar's signature)

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

20121

RECEIVED

District Health Office No. 2,

District File Number 846-986

Date Filed 8-14-46

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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 Mamie Buzencluff

Licensed Embalmer No. 3242

P. O. Address Chaffee 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.