

S. No. 2
100M-5-43
Rev. 5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1435**
Registrar's No. **14**

FILED FEB 10 1947

Registration District No. **148** Primary Registration District No. **3026**

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

48
4
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1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
1106 S. Noland
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 years (Specify whether years, months or days)

In this community 12 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME SABRA ETTA CAMPBELL

3. (b) If veteran, name war None

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Frank W. Campbell

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Nov. 17, 1883
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>63</u>	<u>1</u>	<u>29</u>	hr. _____ min.

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

10. Usual occupation Housewife

MOTHER FATHER

11. Industry or business _____

12. Name Thomas Hayes

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

14. Maiden name Laura Street

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

16. (a) Informant Frank W. Campbell

(b) Address 1106 S. Noland

17. (a) Removal Removal (b) Date thereof 1-19-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall Inc

18. (a) Signature of funeral director Geo. C. Carson

(b) Address Independence, Mo

19. (a) 1-30-47 (b) Geo. C. Carson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1106 S. Noland
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from March 1945 to Jan 16, 1947
that I last saw her alive on Jan 9, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Hypertensive cardiac vascular disease with generalized arterial sclerosis. Coronary insufficiency left bundle branch block

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

93D

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? _____

23. Signature Charles Nicholson Jr (M. D. or other) _____
Address Independence Mo. Date signed Jan 18-47

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.....

Chas J Taylor, Registered Apprentice No. *411*
working under my personal supervision.

Signed.....*Floyd Carson*

Licensed Embalmer No. *4199*

P. O. Address *Independence*

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.