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Impson

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12159**

FILED APR 28 1947

Registration District No. 381

Primary Registration District No. 4575

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(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 82 years, months or days

3. (a) PRINT FULL NAME Hulda Campbell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife dead John Campbell 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) 8 - (Day) 24 (Year) 1864

8. AGE: Years 82 Months 6 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business House wife

MOTHER FATHER

12. Name James C. Lidewell
13. Birthplace Maine Co. (City, town, or county) Ind (State or foreign country)
14. Maiden name Sarah A. Black
15. Birthplace _____ (City, town, or county) Ind (State or foreign country)

16. (a) Informant Paul Lidewell
(b) Address Milan Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-47 (Month) (Day) (Year)

(c) Place: burial or cremation Oakwood Milan

18. (a) Signature of funeral director W. H. Harris

(b) Address Milan Mo

19. (a) April 1-1947 (Date received local registrar) (b) Mrs. H. B. Harris (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan
(c) City or town Milan Mo (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 19 year 1947 hour 8 minute 24 a.m.
21. I hereby certify that I attended the deceased from Feb. 22, 1946, to March 19, 1947, that I last saw her alive on 3-19, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Hypertension
Due to Smoking

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 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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature W. H. Harris (M: D. or other) _____
Address Milan Date signed 3/19/47

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 10
District File Number H-#7-6-20
Date APR - 5 1947

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..... *Dwight Schaefer*

Licensed Embalmer No. *2667*

P. O. Address *Urbana 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.