

FILED APR 30 1947
Registration District No. _____

Primary Registration District No. 6273

1. PLACE OF DEATH: *Worth*
(a) County *Worth*
(b) City or town *Rural New Grant Co Mo*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: *1*
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution *9 mo.* (Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME *Elizabeth 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 *Widow*
(b) Name of husband or wife *William Campbell*
(c) Age of husband or wife if alive *22* years
7. Birth date of deceased *May 22 1858*
(Month) (Day) (Year)

8. AGE: Years *88* Months *9* Days *15*
If less than one day hr. _____ min. _____

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

10. Usual occupation *House Keeper*

11. Industry or business _____

MOTHER FATHER { 12. Name *Johnathon Stuck*
13. Birthplace *Iowa*
(City, town, or county) (State or foreign country)
14. Maiden name *Mary Glenn*
15. Birthplace *Iowa*
(City, town, or county) (State or foreign country)

16. (a) Informant *Frank Campbell*

(b) Address *Front City Mo*

17. (a) *Burial* (b) Date thereof *3/19/47*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Caldonia Ia*

18. (a) Signature of funeral director *C. O. Woodruff*

(b) Address *Mount Pleasant Ia*

19. (a) *3-27-47* (b) *Leta D. Dabson*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State *Iowa* (b) County *Ringgold*
(c) City or town *Worth*
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If usually give location)
(e) Citizen of foreign country? *✓* (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *March* day *17*
year *1947* hour *4* minute *30 P.M.*
21. I hereby certify that I attended the deceased from *Sept 10*
14 to *3-17* 19*47*
that I last saw her alive on *3-10* 19*47*
and that death occurred on the date and hour stated above.

Immediate cause of death *Mitral regurgitation of heart*
Duration *5 yrs*

Due to _____

Due to _____

Other conditions *Arteriosclerosis*
(Include pregnancy within 3 months of death)

Major findings: *✓*
Of operations _____
Of autopsy *no*
PHYSICIAN *10/40*
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? *✓*

While at work? *✓* (Specify type of place) (e) Means of injury *3*

23. Signature: *Leta D. Dabson* (at D. or other) _____

Address *Worth Ia* Date signed *3-28-47*

FEB 10 1944

DISTRICT HEALTH OFFICE
Cameron, Mo.

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

B. C. Phoadis

Licensed Embalmer No.

2479

P. O. Address

Mt Air Jn

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.