

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 14 1947
128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20647
Registrar's No. 573

Registration District No. 128 Primary Registration District No. 5465

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **Springfield - Rural Campbell Twp.**
(c) Name of hospital or institution:
1309 Clifton,
(d) Length of stay: **43 Years**
In this community **43 Years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Greene 39**
(c) City or town **Springfield - Rural**
(d) Street No. **1309 Clifton**
(e) Citizen of foreign country? **No.**

3. (a) PRINT FULL NAME **Samuel Frank Campbell.**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **500-09-8803**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **May 15, 1904**

8. AGE: Years **43** Months **1** Days **11**
If less than one day hr. min.

9. Birthplace **Greene County Missouri**

10. Usual occupation **Laborer**

11. Industry or business **Laborer**

MOTHER FATHER
12. Name **James Marion Campbell**
13. Birthplace **Mo.**
14. Maiden name **Fanny Culex**
15. Birthplace **Mo.**

16. (a) Informant **Mrs. Mark Shepherd**
(b) Address **Springfield Mo.**

17. (a) **Burial** (b) Date thereof **6-28-47**
(c) Place: burial or cremation **Basaville, Em.**

18. (a) Signature of informant **Springfield Mo. J. G. King**
(b) Address

19. (a) **6-28-47** (b) **W. E. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **26**
year **1947** hour **2** minute **00P.** M.
21. I hereby certify that I attended the deceased from **9-12-1945** to **6-26-1947**
that I last saw him alive on **5-10-1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **arteria sclerosis**
Due to
Due to
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?
(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
23. Signature **W. Kelly** (M. D. or other)
Address **Springfield, Mo.** Date signed **6-29-47**

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

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 May Rhodes

Licensed Embalmer No. 4071

P. O. Address Springfield

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.