

300  
10-47  
17-39  
3906

FILED DEC 30 1948  
Registration District No. 381

Primary Registration District No. 6179

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

1. PLACE OF DEATH:

(a) County SULLIVAN

(b) City or town Pollock - Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Jackson Twip  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether  
years, months or days) (Specify whether

In this community 80 y. 1. 2

3: (a) PRINT FULL NAME SUSAN FRANKIS CAMPBELL

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife Annanias Campbell

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

7. Birth date of deceased May 30 1868  
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 10  
If less than one day hr. min.

9. Birthplace Sullivan Co. N.Y.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer's wife

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

MOTHER FATHER { 12. Name Cain Grindstaff

13. Birthplace don't know  
(City, town, or county) (State or foreign country)

14. Maiden name Mary don't know

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

16. (a) Informant Viril Rogers

(b) Address Newtown - 116

17. (a) 12-12-48 Rural (b) Date thereof 12-12-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Campbell - Cam - Pollock

18. (a) Signature of funeral director Schogone

(b) Address 116 Main St. for Surplus Store

19. (a) Dec. 23-1948 (b) Mrs. H. B. Harris  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 116 (b) County Sullivan <sup>1050</sup>

(c) City or town Pollock - Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Jackson Twip  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 16  
year 1948 hour 7:00 minute 00 A.M.

21. I hereby certify that I attended the deceased from Jan 2  
\_\_\_\_\_ 1948 to Dec 16 1948

that I last saw him alive on Dec 11 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage <sup>Duration</sup> 1 day

Due to arteriosclerosis <sup>years</sup> hypertension

Due to Senile debility

Other conditions Senile debility  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy 830

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury ?

23. Signature Chas. J. Full (M. D. or other) DO

Address Greenfield, MO Date signed 12-16-48

RECEIVED

District Health Officer No. 10

District File Number 12.11.2202

Date Filed DEC 28 1948

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.....

D. Morris Cleeton

, Registered Apprentice No. 338

working under my personal supervision.

Signed August Schauer

Licensed Embalmer No. 2667

P. O. Address Indian, 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.**