

FILED MAR 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8150

BIRTH NO. _____		REG. DIST. NO. <sup>131</sup> 5471		PRIMARY REG. DIST. NO. 5471		Registrar's No. 6			
1. PLACE OF DEATH a. COUNTY <b>GRUNDY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>GRUNDY MO</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>RURAL WASHINGTON TOWNSHIP</b>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>RURAL</b>		d. STREET ADDRESS (If rural, give location) <b>WASHINGTON TOWNSHIP</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION.				d. STREET ADDRESS (If rural, give location) <b>WASHINGTON TOWNSHIP</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>MINTA</b>			b. (Middle) <b>LEAH</b>		c. (Last) <b>CAMPBELL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MAR 6 1949</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>OCT 23 1889</b>		9. AGE (In years last birthday) <b>59</b> IF UNDER 1 YEAR Months <b>4</b> Days <b>13</b> IF UNDER 1 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYVILLE IOWA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>WILLIAM HICKMAN</b>			13b. MOTHER'S MAIDEN NAME <b>MARTHA ARNEY</b>			14. NAME OF HUSBAND OR WIFE <b>CHARLES D. CAMPBELL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT'S SIGNATURE OR NAME <b>DALE CAMPBELL</b>				ADDRESS <b>TRENTON MO.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>1 or 2 yrs</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Interstitial Nephritis</b>				ANTECEDENT CAUSES					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.					
DUE TO (b) _____				DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death. <b>Secondary Anemia</b>					
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>July 1, 1948</b> , to <b>March 6, 1949</b> , that I last saw the deceased alive on <b>March 1, 1949</b> , and that death occurred at <b>5:15 P.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>N. H. Sellers M.D.</b>				23b. ADDRESS <b>Trenton, Mo</b>			23c. DATE SIGNED <b>3-7-49</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>MAR-8-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>FOX CEM.</b>		24d. LOCATION (City, town, or county) (State) <b>GRUNDY CO. MO.</b>			
DATE REC'D BY LOCAL REG. <b>March 8 1949</b>		REGISTRAR'S SIGNATURE <b>Miss Nathan Cooper</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Schoolers</b>		ADDRESS <b>Funeral Home Spickard Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed Rose Wise.....

Signed.....  
Student Embalmer

Licensed Embalmer No. 3771

P. O. Address Spickard Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**