

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10-48

FILED OCT 9 1950

BIRTH NO. 64427-50 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 867

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> <u>0396</u>	
b. CITY OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u> <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Johns Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>1113 South New</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Debra</u> b. (Middle) <u>Ann</u> c. (Last) <u>Campbell</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>October 2 1950</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>Oct 2, 1950</u>	9. AGE (In years last birthday) <u>Infant</u>	IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u> <u>0</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Robert M Campbell</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Lou Vickery</u>	14. NAME OF HUSBAND OR WIFE <u>---</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Robert M Campbell, Springfield, Mo.</u> ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>751X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Spina - Bifida</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congenital</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Talipes equino - varus</u> <u>Mangoliam (probable)</u>			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>---</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>---</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>---</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) <u>---</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>---</u>
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22. I hereby certify that I attended the deceased from Oct 2, 1950, to Oct 2, 1950, that I last saw the deceased alive on Oct 2, 1950, and that death occurred at 1:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. L. Johnston md</u>	23b. ADDRESS <u>Springfield, Mo</u>	23c. DATE SIGNED <u>10-5-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct 3, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>10-7-50</u>	REGISTRAR'S SIGNATURE <u>W E Handley md</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Lohmeyer</u> ADDRESS <u>Springfield, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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Dah

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.

Student
Student Embalmer

Signed _____

Carl J. Glenn

Licensed Embalmer No. _____

4707

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.