

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26652**  
Registrar's No. **747**

FILED SEP 11 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5463** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>GREENE</b> <b>0390</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>JACKSON RURAL</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>0390</b>	
c. LENGTH OF STAY (In this place)		OR TOWN <b>2ND. JACKSON RURAL, Strafford</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>RT2 STRAFFORD</b>		d. STREET ADDRESS (If rural, give location) <b>RT. 2 STRAFFORD</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>CLARA</b>	b. (Middle) <b>LEE</b>	c. (Last) <b>CAMPBELL</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>AUGUST 30 1951</b>
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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>JUNE 4 1883</b>	9. AGE (In years of last birthday) <b>68</b>	10. MONTHS <b>0</b>	11. DAYS <b>0</b>	12. HOURS <b>0</b>	13. MIN. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>IN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>ALLEN BROWN</b>	13b. MOTHER'S MAIDEN NAME <b>MARY JANE</b>	14. NAME OF HUSBAND OR WIFE <b>R. A. CAMPBELL</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT'S SIGNATURE OR NAME <b>R. A. CAMPBELL</b>	ADDRESS <b>RT 2 STRAFFORD, Mo</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>A few yrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart disease with Auricular fibrillation</b>		
	ANTECEDENT CAUSES 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **8/28**, 19**51**, to **8/30**, 19**51**, that I last saw the deceased alive on **8/28**, 19**51**, and that death occurred at **3:30a** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Russ D. Callaway MD</b> (Degree or title)	23b. ADDRESS <b>Springfield</b>	23c. DATE SIGNED <b>9/1/51</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>SEPT. 1-1951</b>	24c. NAME OF CEMETERY OR CREMATORY <b>BASSVILLE CEMETERY EAST OF STRAFFORD, MO.</b>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <b>9-1-51</b>	REGISTRAR'S SIGNATURE <b>W. E. Handley MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Klugger &amp; Co. Springfield</b>	ADDRESS <b>m.B.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 29 1957

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 Ogle Slom Jr

Licensed Embalmer No. 4176

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.