

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10-48

FILED FEB 28 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 185

1. PLACE OF DEATH a. COUNTY <b>GREENE</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) OR TOWN <b>SPRINGFIELD</b>		c. CITY OR TOWN <b>SPRINGFIELD</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BURGE HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>2331 N. EAM KELLETT</b> <u>0396</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>CALLIE</b> b. (Middle) <b>MELINDA</b> c. (Last) <b>CAMPBELL</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>FEB. 25, 1955</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>JULY 7, 1891</b>
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>	9. AGE (In years last birthday) <b>63</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>MARTIN</b>	13b. MOTHER'S MAIDEN NAME <b>JACKSON</b>	14. NAME OF HUSBAND OR WIFE <b>CLAUDE CAMPBELL</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>CLAUDE CAMPBELL</b> ADDRESS <b>SPRINGFIELD, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Sarcoma of uterus</b>		
	ANTECEDENT CAUSES Morbidity 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 Dec 24, 1955, to Feb 25, 1955, that I last saw the deceased alive on Feb 24, 1955, and that death occurred at 4:40 pm., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) <b>D. Dean Cunningham M.D.</b>	23b. ADDRESS <b>1715 Coonville Springfield Mo</b>	23c. DATE SIGNED <b>2-25-55</b>
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24a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>2-27-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>GREENLAW CEME.</b>	24d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO</b>
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DATE REC'D BY LOCAL REG. <b>2-25-55</b>	REGISTRAR'S SIGNATURE <b>Edith Williamson</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>W. King</b> ADDRESS <b>Ho Sald Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed.....  
*Ogle Stone Jr.*

Licensed Embalmer No. ....

P. O. Address.....  
*Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.