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FILED AUG 31 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25464

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 5135 Registrar's No. 472

1. PLACE OF DEATH  
a. COUNTY Butler

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Missouri b. COUNTY Butler

b. CITY (If outside corporate limits, write RURAL and give OR TOWN Rural, Ash Hill, Mo.)

c. LENGTH OF STAY (in this place) 7 Yrs

c. CITY OR TOWN Rural

d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION 3 Mi N.W. of Fisk

STREET ADDRESS (If rural, give location) 3 Mi N.W. of Fisk

3. NAME OF DECEASED  
a. (First) AGeorgeer b. (Middle) Wilbur c. (Last) Campbell

4. DATE OF DEATH (Month) (Day) (Year) 7 15 55

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 1-15-1890

9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months 6 Days 20 IF UNDER 24 HRS. Hours 20 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farmer

11. BIRTHPLACE (City and State or Foreign Country) Carmi Ill.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Alexander Campbell

13b. MOTHER'S MAIDEN NAME Jane English

14. NAME OF HUSBAND OR WIFE Mary A. Campbell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT'S SIGNATURE OR NAME ADDRESS John Campbell Fisk, Mo.

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  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Metastatic Carcinoma  
  
ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) CARCINOMA PROSTATE  
  
DUE TO (c) \_\_\_\_\_  
  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES  NO

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) 177x

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ONE VISIT, 1955, to 7-15, 1955, that I last saw the deceased alive on 7-15, 1955, and that death occurred at 1 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. Shlemmer MD

23b. ADDRESS Puxico Mo

23c. DATE SIGNED 7/18/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-17-55

24c. NAME OF CEMETERY OR CREMATORY Shain Memorial

24d. LOCATION (City, town, or county) (State) Butler Co. Mo.

DATE REC'D BY LOCAL REG. 8/23/55

REGISTRAR'S SIGNATURE Ph. Mueller

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fisk, Mo.

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

RECEIVED  
AUG 29 1955  
BUTLER CO. HEALTH CENTER  
FILE No. \_\_\_\_\_

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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 *Raymond L. Duff*

Licensed Embalmer No. *47*

P. O. Address *Bermis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.