

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25799

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 736

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>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>	c. LENGTH OF STAY (In this place) <u>15 days</u>	c. CITY OR TOWN <u>Springfield</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DZARK OSTEOPATHIC HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>1613 South National</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Evalena</u> b. (Middle) _____ c. (Last) <u>Campbell</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>8-21-1955</u>
--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb. 17, 1875</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
----------------------	-------------------------------	---	---------------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Mayseville, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	---	--	---

13a. FATHER'S NAME <u>John Gist</u>	13b. MOTHER'S MAIDEN NAME <u>Evaline Wilson</u>	14. NAME OF HUSBAND OR WIFE <u>James E. Campbell</u>
-------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No.</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. R.R. Reynolds</u> ADDRESS <u>Springfield, Mo. 1613 S. National</u>
--	------------------------------------	--

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Circulatory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) <u>Decompensated hypertensive heart disease</u>		
	DUE TO (c) <u>Arteriosclerosis</u> <u>443XF</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of neck of left femur</u>			

19a. DATE OF OPERATION <u>8/10/55</u>	19b. MAJOR FINDINGS OF OPERATION <u>Fracture of neck of left femur</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---------------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	21c. (CITY, TOWN, OR TOWNSHIP) <u>Springfield, Mo.</u> (STATE) <u>Mo.</u>
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>8 6 1955 9:30 a.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Patient fell down 2 steps.</u>
---	---	--

22. I hereby certify that I attended the deceased from 8/6/, 19 55, to 8/21, 19 55, that I last saw the deceased alive on 8/21/55, 19 55, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Edward E. Wetzel, D.O.</u>	23b. ADDRESS <u>700 E. Sunshine, Springfield</u>	23c. DATE SIGNED <u>8/22/55</u>
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Aug 23, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
--	-------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>8-22-55</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. ...</u> ADDRESS <u>...</u>
---	---	--

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

DEC 8 1955

OCT 10 1955

DEC 7 1955

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 *Lester G. ...*

Licensed Embalmer No. 31

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