

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025149  
STATE FILE NUMBER

FILED AUG 4 1958 Registration District No. 128 Primary Registration District No. 200 Registrar's No. 744

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>MARSHFIELD MO</b> 1120 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION <b>DAVIS NURSING HOME</b>		Length of stay in lb <b>3 MO</b>	d. STREET ADDRESS (If outside, give location) <b>215 W WASHINGTON</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W</b> Last <b>CAMPBELL</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>25</b> Year <b>1958</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 28 1866</b>	9. AGE (In years) Last birthday <b>91</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET OPTOMETRIST</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>INDIANA 1</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13a. FATHER'S NAME <b>ABNER CAMPBELL</b>		13b. MOTHER'S MAIDEN NAME <b>DORA COMPTON</b>		14. NAME OF HUSBAND OR WIFE	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>H.K. CAMPBELL</b>	Address <b>MARSHFIELD</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis, acute</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SEV. SECONDS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) <b>4201</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Springfield, Mo.</b>	COUNTY <b>MO</b>	STATE
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21. I attended the deceased from **4-22-58** to **7-25-58** and last saw him alive on **7-23-58**  
Death occurred at **9:15 P.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>G. Blummond MD</b> (Degree or title)	22b. ADDRESS <b>Springfield, Mo.</b>	22c. DATE SIGNED <b>7-29-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>7-28-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SEYMOUR</b>	23d. LOCATION (City, town, or county) <b>SEYMOUR MO</b>
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24. FUNERAL DIRECTOR <b>BARBER EDWARDS</b>	ADDRESS <b>MARSHFIELD</b>	25. DATE RECD. BY LOCAL REG. <b>7-30-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *George Stapp* .....

Licensed Embalmer No. *3161* .....

P. O. Address *Wm. Henry, Jr.* .....

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.