

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039508
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1189

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS (If outside, give location) 3033 Bolivar Road	

3. NAME OF DECEASED (Type or print) First Middle Last May Appleby Campbell			4. DATE OF DEATH Month Day Year December 8, 1958		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Nov. 1886	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William E. Appleby	13b. MOTHER'S MAIDEN NAME Mary Dysart	14. NAME OF HUSBAND OR WIFE Ernest Campbell
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Ernest Campbell	Address Springfield, Mo.
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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) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 5 yrs
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cholecystitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
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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 COUNTY STATE
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21. I attended the deceased from Feb 1946 to 12-8-58 and last saw her alive on 12-8-58
Death occurred at 6:10 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE St. P. Moody M.D.	(Degree or title) C	22b. ADDRESS 609 Cherry Springfield, Missouri	22c. DATE SIGNED 12/10/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-11-58	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Missouri
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24. FUNERAL DIRECTOR J.W. KLINGNER & CO.	ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 12-12-58	26. REGISTRAR'S SIGNATURE Effie E. Melton
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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CAUSES THAT ARE NOT CAUSALLY RELATED

MEDICAL CERTIFICATION

o.s.

OCT 4 1962

SEP 1 1 1962

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 *Mal Fude*

Licensed Embalmer No. 407

P. O. Address *Spring*

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.