

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-004758

FILED VS FEB 3 1960 240

Registration District No. 240 Primary Registration District No. 3075 Registrar's No. 8

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Stoddard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Stoddard</b>									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Dexter</b>		Length of stay in 1b		c. CITY OR TOWN <b>Dexter</b>		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>Residence</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>112 So. Park</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Jesse</b> Middle <b>Thomas</b> Last <b>Campbell</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>6,</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-16-1892</b>		9. AGE (last birthday) <b>68</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>20</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber &amp; Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Puxico, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>					
13a. FATHER'S NAME <b>James H. Campbell</b>				13b. MOTHER'S MAIDEN NAME <b>Rachel Hammon</b>				14. NAME OF HUSBAND OR WIFE <b>Marie Campbell</b>					
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. <b>none</b>		17. INFORMANT Address <b>Mrs. Marie Campbell, Dexter, Mo.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia,</b> DUE TO (b) <b>Carcinoma of lung</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>7-3 days</b> <b>1 1/2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Traumatic Jacksonian Epilepsy</b>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <b></b> Month, Day, Year <b></b>		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			
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <b>1:05 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>Walter Strickland-Rainey</b>						22b. ADDRESS <b>Bloomfield, Mo.</b>			22c. DATE SIGNED <b>1-11-60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-8-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Walker</b>			23d. LOCATION (City, town, or county) (State) <b>R.F.D. Bloomfield, Mo.</b>						
24. FUNERAL DIRECTOR <b>Strickland-Rainey</b>				ADDRESS <b>Dexter, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-26-60</b>		26. REGISTRAR'S SIGNATURE <b>Velma V. Jenkins</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OR

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lucille Rainey

: Licensed Embalmer No. 4983

P. O. Address Depton, Va

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.