

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013801

FILED VS APR 11 1960

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 26

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Saline</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Slater</u>		a. STATE <u>Mo</u>		b. COUNTY <u>Saline</u>	
Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>Slater</u>		c. CITY OR TOWN <u>Slater</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>513 Block St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>513 Block</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last				4. DATE OF DEATH Month Day Year			
<u>FANNIE WALKER CAMPBELL</u>				<u>April 7, 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1875</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
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>None</u>		11. BIRTHPLACE (City and state or country) <u>Howard Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Robert H. Metcalf</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Taylor</u>		14. NAME OF HUSBAND OR WIFE <u>George</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war and dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Aubrey Bee Slater, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage.</u>						<u>4-8 wks.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Diabetes</u>							
DUE TO (c) <u>Generalized Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 a.m. p.m. Month, Day, Year							
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 <u>Oct 1954</u> to <u>April 6-60</u> and last saw her alive on <u>April 6-60</u> . Death occurred at <u>Slater Mo at 10:15 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. N. Williams</u> (Degree or title) <u>District M.D.</u>				22b. ADDRESS <u>312 1/2 N. Main Slater</u>		22c. DATE SIGNED <u>4-8-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-10-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Slater, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Haines Funeral Home Slater, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>4-8-60</u>		26. REGISTRARS SIGNATURE <u>Mrs. Raymond Brame</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Ray F. Hays, Jr.*
Licensed Embalmer No. 4630

P. O. Address _____

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.