

# FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## =60-016064

FILED VS APR 22 1960

Registration District No. 182 Primary Registration District No. 5682 Registrar's No. 5

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Linn</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Linn</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>North Salem Twp.</b>		Length of stay in 1b <b>35 yrs</b>		c. CITY OR TOWN <b>New Boston</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RFD New Boston</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>RFD</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>EARL M. CAMPBELL</b>				4. DATE OF DEATH Month Day Year <b>April 14, 1960</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>5-23-1905</b>	9. AGE (last birthday) <b>54</b>	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) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (City and state or country) <b>Mexico, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>US</b>		
13a. FATHER'S NAME <b>Burnett M. Campbell</b>			13b. MOTHER'S MAIDEN NAME <b>Meta McFaul</b>			14. NAME OF HUSBAND OR WIFE <b>Alberta Smith</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>493-42-4806</b>		17. INFORMANT Address <b>Mrs. Alberta Campbell, New Boston, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation from Crushed Chest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Corn Picker fell on Chest</u> DUE TO (c) _____ 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							INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Injury occurred while disconnecting Corn Picker from tractor.</u>							
20c. TIME OF INJURY Hour <b>3:30</b> p.m.	Month, Day, Year <b>4-14-60</b>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>Farm Lot</u>		20f. CITY, TOWN, OR LOCATION <u>North Salem Township</u>		COUNTY <u>Linn</u>	STATE <u>Mo.</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>Approx 3:30 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Wright</u> <b>Coroner</b>				22b. ADDRESS <u>Madville</u> <b>Mo.</b>				22c. DATE SIGNED <b>4/14/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Apr. 17, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bear Branch Cemetery</b>			23d. LOCATION (City, town, or county) <b>Purdin, Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Wright Funeral Home, Brookfield, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>April 16-1960</b>		26. REGISTRAR'S SIGNATURE <u>Mrs. Bessie Kelley</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 Herael B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.