

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-006035

STATE FILE NUMBER

Registration District No. 270 Primary Registration District No. 3050 Registrar's No. 12

FILED VS MAR 3 1961

1. PLACE OF DEATH a. COUNTY <u>Pemiscot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wisc.</u> b. COUNTY <u>Monominee</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Caruthersville, Mo.</u>		Length of stay in 1b <u>1 Day</u>	c. CITY OR TOWN <u>Green Bay</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>1st. &amp; Walker Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>303 N. Quincy</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Campbell</u> Last <u>Campbell</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>19,</u> Year <u>1961</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-1889</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>6</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Monominee, Mich.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>James J. Campbell</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine A. Kelleher</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Roy Campbell</u>
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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) <u>Yes W. W. II&amp;I</u>	17. INFORMANT <u>Family Record</u> Address <u></u>
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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) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	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
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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.) <u>This man fell head</u>
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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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Jerimy Ashum, Coroner</u>	22b. ADDRESS <u>Waukegan, Mo.</u>	22c. DATE SIGNED <u>2-20-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-20-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monominee Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Monominee Mich.</u>
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24. FUNERAL DIRECTOR <u>LaForge Undertkg. Caruthersville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-21-61</u>	26. REGISTRAR'S SIGNATURE <u>Jack W Tipton</u>
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AMENDED  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

MAR 6 1961

SEP 11 1961

**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 Noel C Deane

Licensed Embalmer No. 3941

P. O. Address Caruthouse

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.