

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008507

AMENDED

Registration District No. 137 Primary Registration District No. 3025 Registrar's No. 66 STATE FILE NUMBER

DATE PREPARED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

| | | | |
|---|--|--|--|
| <p>FILED MAR 27 1961</p> <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Henry</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u> Length of stay in lb <u>1 Day</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wetzel Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> | | <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. CITY OR TOWN <u>Missouri</u> b. COUNTY <u>Benton</u></p> <p>c. CITY OR TOWN <u>Barnes Park</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>Ten. Deleving</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> | |
| <p>3. NAME OF DECEASED (Type or print) First Middle Last</p> <p><u>CLYDE A CAMPBELL</u></p> | | <p>4. DATE OF DEATH Month Day Year</p> <p><u>3-18-1961</u></p> | |
| <p>5. SEX <u>Male</u></p> | <p>6. COLOR OR RACE <u>white</u></p> | <p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p> | <p>8. DATE OF BIRTH <u>10-10-1886</u></p> |
| <p>9. AGE (last birthday) <u>74</u></p> | | <p>IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u></p> | <p>IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u></p> |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u></p> | | <p>10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u></p> | <p>11. BIRTHPLACE (City and state or country) <u>Lafayette Co. Mo.</u></p> |
| <p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p> | | <p>13a. FATHER'S NAME <u>Neal S Campbell</u></p> | |
| <p>13b. MOTHER'S MAIDEN NAME <u>Doris Ann</u></p> | | <p>14. NAME OF HUSBAND OR WIFE <u>none</u></p> | |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p> | | <p>16. SOCIAL SECURITY NO. <u>no</u></p> | |
| <p>17. INFORMANT Address <u>Mrs J. A. Wetowack Barnes Park Mo</u></p> | | <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> | |
| <p>IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u></p> | | <p>INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u></p> | |
| <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial Insufficiency</u></p> | | <p><u>3 wks</u></p> | |
| <p>DUE TO (c) <u>Chronic Broncho-pulmonary disease</u></p> | | <p><u>years</u></p> | |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Asthma Bronchiectasis Emphysema</u></p> | | <p>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</p> | |
| <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p> | |
| <p>20c. TIME OF INJURY Hour <u>-</u> s.m. <u>-</u> p.m. <u>-</u> Month, Day, Year <u>-</u></p> | | <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> | |
| <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>20f. CITY, TOWN, OR LOCATION</p> | <p>COUNTY STATE</p> |
| <p>21. I attended the deceased from <u>3-16-61</u> to <u>3-18-61</u> and last saw her/him alive on <u>3-18-61</u></p> <p>Death occurred at <u>3:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p> | | | |
| <p>22a. SIGNATURE (Degree or title) <u>Clinton L. Glassy DO</u></p> | | <p>22b. ADDRESS <u>Clinton, Mo.</u></p> | <p>22c. DATE SIGNED <u>3/20/61</u></p> |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p> | <p>23b. DATE <u>3/21/1961</u></p> | <p>23c. NAME OF CEMETERY OR CREMATORY <u>Englewood</u></p> | <p>23d. LOCATION (City, town, or county) <u>Clinton Mo</u> (State)</p> |
| <p>24. FUNERAL DIRECTOR ADDRESS <u>F. L. SCHABER9 CLINTON MO</u></p> | | <p>25. DATE RECD. BY LOCAL REG. <u>Mar 24, 1961</u></p> | <p>26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u></p> |

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 F. T. Schaberg

Licensed Embalmer No. 4513

P. O. Address Clermont

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.