

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013301

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. _____ Registrar's No. 412

AMENDED **FILED MAY 1 1961**

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Strafford</u>		Length of stay in 1b	c. CITY OR TOWN <u>Strafford</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Route #2</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route #2</u>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Basil</u> Last <u>Cambell</u>			4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-1896</u>	9. AGE (last birthday) <u>64</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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Greene Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>William F. Cambell</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Hester</u>		14. NAME OF HUSBAND OR WIFE <u>never married</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Charlie Cambell, Strafford, Mo.</u>		
				Address		

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 <u>Sudden</u>
IMMEDIATE CAUSE (a) <u>Likely Cerebral-Vascular Pathology</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Likely Cerebral and Generalized</u>	
DUE TO (c) <u>Atherosclerosis</u>		<u>Unknown</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Semi-invalid</u>		PART III. If deceased was female was there a pregnancy in last 90 days. UNATTENDED BY A PHYSICIAN <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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	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 CEMETERY and last saw her/him alive on _____
Death occurred at 10:45a. m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <u>James R. Amos, M.D.</u>		22b. ADDRESS <u>Greene County Health Officer, Spfld Mo</u>		22c. DATE SIGNED <u>4-28-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-27-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bass Chapel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Greene Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>Rex Rainey, Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-28-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>	

DATE AWIENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 *Lea Mason*

Licensed Embalmer No. 4568

P. O. Address Springfield

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.