

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-030076

STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 305

FILED SEP 15 1961

1. PLACE OF DEATH a. COUNTY <b>Marion</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		Length of stay in 1b	c. CITY OR TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1705 Prince Ave.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1705 Prince Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Charley</b> Middle <b>C.</b> Last <b>Campbell</b>			4. DATE OF DEATH Month <b>8</b> Day <b>29</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/18/1905</b>	9. AGE (last birthday) <b>55</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C.B. &amp; R. CO.</b>	11. BIRTHPLACE (City and state or country) <b>Hull, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Charles M. Campbell</b>		13b. MOTHER'S MAIDEN NAME <b>Hattie Riley</b>		14. NAME OF HUSBAND OR WIFE <b>Leona E. Campbell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>			17. INFORMANT Address <b>Miss Fern Campbell, 112 S. 8th</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) <b>Inanition</b> DUE TO (b) <b>Carbosis of liver</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>8 mo</b>	
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 _____, to _____ and last saw her/him alive on _____. Death occurred at <b>7:25 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>R. M. O'Donnell</b> (Degree or title)			22b. ADDRESS		22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/1/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grand View Burial Park Hannibal, Mo.</b>	
24. FUNERAL DIRECTOR <b>H. M. C'Donnell, Hannibal, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9/11/61</b>		26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Luske by Lillian M. Herman</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

**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 *J. M. McDonnell*

Licensed Embalmer No. 3889

P. O. Address Hannibal, Mo.

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.