

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-017887

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 44 STATE FILE NUMBER _____

FILED MAY 23 1962

VS 300 Rev. 4/59

1 0030

2 0030

3

4 1

5 2

6

7 0

8 0

9 332X

10

11

12 1-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Atchison | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Atchison | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fairfax | | c. CITY OR TOWN Fairfax | |
| Length of stay in 1b 1 day | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Hospital | | d. STREET ADDRESS (If outside, give location) 3Mi.S.E.of Fairfax | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED First Middle Last ELLA C. CAMPBELL | | | 4. DATE OF DEATH Month Day Year May 12 1962 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7/8/1867 |
| 9. AGE (last birthday) 94 | | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY In the home | 11. BIRTHPLACE (City and state or country) Atchison Co., Mo. |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Robert Christan | |
| 13b. MOTHER'S MAIDEN NAME Mary Holdiway | | 14. NAME OF HUSBAND OR WIFE Deceased | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Arch Campbell Fairfax, Mo. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis | | | INTERVAL BETWEEN ONSET AND DEATH 12 hours |
| 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"/> N. <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 checked="" 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 July 1952 to May 12 1962 and last saw her/him alive on May 12, 1962 Death occurred at 5 am on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Wallace Carpenter MD | | 22b. ADDRESS Rock Port mo | 22c. DATE SIGNED 5-18-62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 5/14/1962 | 23c. NAME OF CEMETERY Pleasant Ridge | 23d. LOCATION (City, town, or county) (State) Fairfax Mo. |
| 24. FUNERAL DIRECTOR Schooler Funeral Home ADDRESS Fairfax, Mo. | | 25. DATE RECD. BY LOCAL REG. May 19, 1962 | 26. REGISTRAR'S SIGNATURE Therwin N. Schooler |

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 Marvin H. Schaefer

Licensed Embalmer No. 4162

P. O. Address Fairfax Va.

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.