

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Harrison

Township Jefferson

Village Bethany

City Bethany (NO. 1)

Registration District No. 334

File No. 21594

Primary Registration District No. 5467

Registered No. 39

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Alfred Campbell

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Nov 17, 1852
(Month) (Day) (Year)

AGE 63 yrs. 8 mos. 1 ds. IF LESS than 1 day, ___ hrs or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) Good

BIRTHPLACE (City or town, State or foreign country) Ill.

PARENTS
NAME OF FATHER Robert Campbell
BIRTHPLACE OF FATHER (City or town, State or foreign country) Penn.
MAIDEN NAME OF MOTHER Matildia Dolan
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Penn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kate Noble

(ADDRESS) Bethany

Filed July 18, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 17, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from Sweden, 1915, to Sweden, 1915, that I last saw him alive on July 4, 1915, and that death occurred, on the date stated above, at 1 a m.
The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage
instinctively
Contributory Arterio Sclerosis
(Duration) several mos. ds.
(Signed) J. H. Wells
17-19, 1915 (Address) Winstonsville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

(LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS))

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Wagon Run DATE OF BURIAL 7-18, 1915

UNDERTAKER J. H. Wells ADDRESS Winstonsville

If information should be carefully supplied, AGE should be stated in plain terms, so that it may be properly classified. Exact statement of DEATH in plain terms, so that it may be properly classified. Exact statement of DEATH in plain terms, so that it may be properly classified.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Harrison
Township Union
or Village
or City

Registration District No. _____ File No. _____
Primary Registration District No. _____ Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME James Herbert Campbell
(NO. _____) St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

SEX Male
COLOR OR RACE White
SINGLE MARRIED
WIDOWED OR DIVORCED
(If file the word)
DATE OF BIRTH July 17, 1915
(Month) (Day) (Year)
AGE 63 yrs. 7 mos. 7 days, _____ hrs. or _____ min.?
PLACE OF BIRTH Missouri

OCCUPATION, profession, or particular kind of work
Electrician
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
Electrician

BIRTHPLACE (City or town, State or foreign country)
St. Louis, Missouri

NAME OF FATHER
Robert Campbell

BIRTHPLACE OF FATHER (City or town, State or foreign country)
St. Louis, Missouri

MAIDEN NAME OF MOTHER
Elizabeth Campbell

BIRTHPLACE OF MOTHER (City or town, State or foreign country)
St. Louis, Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edith Campbell
(ADDRESS) 137 Hicknell
Filed July 19, 1915 REGISTRAR Edith Campbell

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 17, 1915
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from July 17, 1915 to July 17, 1915
that I last saw him alive on July 17, 1915
and that death occurred, on the days stated above, at 11 a. m.
THE CAUSE OF DEATH* was as follows:
Stroke

Contributory (Secondary) indirectly
(Signed) Edith Campbell
Duration (in months) _____
Duration (in years) _____

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injuria and (2) whether Accidental, Suicidal, or Homicidal.
M. D. _____

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Mass Cemetery
DATE OF BURIAL July 18, 1915
UNDERTAKER 137 Hicknell
ADDRESS Massachusetts

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

N. B.—Every item on this form should be filled in. If the cause of death is not known, state "Cause of death unknown." If the cause of death is not known, state "Cause of death unknown." If the cause of death is not known, state "Cause of death unknown."

1 PLACE OF DEATH
 County Harrison REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW
 Township Jefferson Registration District No. 334 File No. 5
 or Village or Primary Registration District No. 5467 Registered No. 39
 City (NO. St. Ward) If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alfred Campbell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W. 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
 (Write the word)
 6 DATE OF BIRTH Satisfactory Information Supplied
 (Month) (Day) (Year)
 7 AGE Satisfactory Information Supplied
 yrs. mos. ds. IF LESS than 1 day hrs. or min.?
 8 OCCUPATION (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17 1915
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied
 that I last saw h. alive on Satisfactory Information Supplied
 and that death occurred, on the date stated above, at Satisfactory Information Supplied
 The CAUSE OF DEATH* was as follows:

9 BIRTHPLACE (City or town, State or foreign country)
 PARENTS
 10 NAME OF FATHER
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
 12 MAIDEN NAME OF MOTHER
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

CONTRIBUTORY (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) M. D.
 191 (Address)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant)
 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted if not at place of death?
 Former or usual residence

15 Filed July 19 1915 Leue Webb
 Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
 20 UNDERTAKER ADDRESS

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

46512

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples; (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite);

Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)