

REC'D APR 18 1939

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

10431  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Cass Registration District No. 162  
(b) Township West Peculiar Primary Registration District No. 5227  
(c) City ..... (d) Street No. ....  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME WILLIAM FRANKLIN CAMP

(a) Residence, No. 510 Cass Co. St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF no history obtainable

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. (?) 1863

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
75 7 (?)

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farming  
9. Industry or business in which work was done, as saw mill, bank, etc. ....  
10. Date deceased last worked at this occupation (month and year) March 1939  
11. Total time (years) spent in this occupation 29 yr

12. BIRTHPLACE (CITY OR TOWN) Evansville, Ind.  
(STATE OR COUNTRY)

13. NAME not known  
14. BIRTHPLACE (CITY OR TOWN) not known  
(STATE OR COUNTRY)

15. MAIDEN NAME not known  
16. BIRTHPLACE (CITY OR TOWN) not known  
(STATE OR COUNTRY)

17. INFORMANT Joel Knight,  
(ADDRESS) Peculiar, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Peculiar Cem DATE Mar 18 39

19. FUNERAL DIRECTOR W. A. Moore 153  
(ADDRESS) Harrisonville Mo

20. FILED 3/18 19 39 Walter P. Robinson  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 17 19 39

22. I HEREBY CERTIFY, That I attended deceased from March 4, 1939, to March 17, 1939

I last saw him... alive on March 16, 1939 Death is said

to have occurred on the date stated above, at 6:00 Am.

The principal cause of death and related causes of importance were as follows:

Pneumonia, bronchial

Date of onset  
3-12-39

Other contributory causes of importance: flu

Influenza

2-28-39

Name of operation ..... Date of .....

What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19 .....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) W. A. Moore, M. D.

(Address) Cleveland, No.

STATEMENT BY LICENSED EMBALMER

I, Hoyd Atkinson, Licensed Embalmer No. 3920

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Prepared for Burial

L. E.

No. \_\_\_\_\_ or by me, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Hoyd Atkinson

Licensed Embalmer No. 3920

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.)