

FILED JAN 25 1940

Registration District No. **761**

Primary Registration District No. **2935**

Registrar's No. **876**

1. PLACE OF DEATH:

(a) County **Polk**  
(b) City or town **Dunnegan, Mo.**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days **2**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Polk**  
(c) City or town **Dunnegan**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **D.H. Campbell**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Nov. 1 1858**  
(Month) (Day) (Year)

8. AGE: Years **82** Months **I** Days **I5** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Dunnegan, Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Glava Campbell**  
13. Birthplace **Tenn.**  
(City, town, or county) (State or foreign country)

{ 14. Maiden name **Sarah Thompson**  
15. Birthplace **Tenn.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Beulah Rice**  
(b) Address **Dunnegan, Mo.**

17. (a) **Burial** (b) Date thereof **12-18-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Dunnegan, Mo.**

18. (a) Signature of funeral director **Frederick W. Barker**

(b) Address **Fair Play, Mo.**

19. (a) **12/18** (b) **J. G. Roberts**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** **16** day  
year **1940** hour **2.30** minute **P** M.

21. I hereby certify that I attended the deceased from **Dec 4**  
19 **40** to **Dec 16** 19 **40**  
that I last saw him alive on **Dec 8** 19 **40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho pneumonia** Duration **8 days**

Due to **senility**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: #  
Of operations #  
Of autopsy #

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) #  
(b) Date of occurrence #  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **Chas H Brown** (M. D. or other)  
Address **Fair play Mo** Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7<sub>2</sub>  
District File Number 1-41-152  
Date Filed 1-14-41

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**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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed Frank Grable Jr.

Licensed Embalmer No. 4140

P. O. Address Baliviar, 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 this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 435-62

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 701

Primary Registration District No. 5935

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Polk  
(b) City or town Campbell  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Dorothy H. Campbell

20. DATE OF DEATH

Month Dec day 16  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immature cause of death \_\_\_\_\_

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Chas. H. Brown (M. D. or other) \_\_\_\_\_

Address Fairplay Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

S-43562