

MAR 11 1941

Registration District No. 89

Primary Registration District No. 3007

Registrar's No. 117

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lucy Lee Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution few days
(Specify whether years, months or days)
In this community most of life

3. (a) PRINT FULL NAME James Jackson 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 _____
6. (b) Name of husband or wife Vina Campbell 6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased Nov 22 (Month) (Day) (Year) 1883

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>3</u>	<u>12</u>	hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Frank Campbell

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

14. Maiden name Sarah Allen

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

16. (a) Informant wife Mrs Vina Campbell
(b) Address Oslin Mo.

17. (a) Burial (b) Date thereof Mar. 5-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oslin Cemetery

18. (a) Signature of funeral director Landers F. Home
(b) Address Campbell Mo. D D

19. (a) 3/7/41 (b) Kate Lutz
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Butler 12
(c) City or town Oslin "Rural" (If outside city or town limits, write "RURAL")
(d) Street No. "Rural" (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 7th year 1941 hour 11 minute 35 a.m.

21. I hereby certify that I attended the deceased from Feb: 24 1941 to March 4 1941; that I last saw him alive on March 4 1941; and that death occurred on the date and hour stated above.

Immediate cause of death
Broncho pneumonia
Due to uremia
Due to Acute nephritis
Other conditions (Include pregnancy within 3 months of death): _____

Duration
<u>3 days</u>
<u>2 days</u>
<u>10 days</u>

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? _____

23. Signature J. P. Wheeler (Specify type of place) (e) Means of injury _____
While at work? _____
Address Poplar Bluff Mo Date signed 3/6/41

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

2
7
3

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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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

6400
Do not use this space.

1. PLACE OF DEATH

(a) County Butler Registration District No. 89
(b) Township _____ Primary Registration District No. 3007 Registered No. _____
(c) City Paplar Bluff (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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

James Jackson Campbell
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 57 3 12
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
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) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

FATHER 13. NAME _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19.

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19. _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 4, 1941

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Prostatic Pneumonia Date of onset _____
Toxemia

Acute Nephritis 10/7

Other contributory causes of importance: _____

unknown - no history of Ch. Nephritis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____ If so, specify _____

(Signed) J. H. Kneibert, M. D.
(Address) Paplar Bluff, Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

J. H. Kneibert (M.D.) Paplar Bluff Mo

