S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 29 1945

State File No. 6

Registration District No. 128 | Primary Registration District No. 2000 | Registrar's No. 627

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 460 S. Grant
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether years, months or days)
In this community 4 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield,
(If outside city or town limits, write "RURAL")
(d) Street No. 460 S. Grant
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary Jane Campbell
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Walter S. Campbell
6. (c) Age of husband or wife if alive Unknown years
7. Birth date of deceased May (Month) 18, (Day) 1865 (Year)
8. AGE: Years 80 | Months 2 | Days 22 | If less than one day hr. min.
9. Birthplace Unknown (City, town, or county) Kentucky (State or foreign country)
10. Usual occupation Housewife
11. Industry or business In Home
FATHER
12. Name William Wall
13. Birthplace Unknown (City, town, or county) Kentucky (State or foreign country)
MOTHER
14. Maiden name Ava Hatter
15. Birthplace Unknown (City, town, or county) Kentucky (State or foreign country)
16. (a) Informant Mr. WalterS. Campbell
(b) Address Springfield, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof August 12, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn Cemetery
18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri
19. (a) 8-11-45 (Date received local registrar) (b) Dr W E Hendly (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 10th, year 1945 hour 2:05 minute A.M.
21. I hereby certify that I attended the deceased from at 12 midnight 8-10, 1945 to 8-10, 1945 that I last saw her alive on 8-10-45 1 P.M. 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Abdominal distension with gas due to indigestion	
Due to Infirmities of age	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature J. M. King M.D. (M. D. or other)
Address Springfield Mo Date signed 8-11-45

984 (Licensed Embalmer's Statement on Reverse Side)

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 Lewis G Schaupf

Licensed Embalmer No. 3842

P. O. Address Springfield, 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, fact should be so stated above.