

FILED JUL 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23202

BIRTH NO. 41369-49 REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 3023 Registrar's No. 171

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

| | | | |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Henry</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u> | |
| b. CITY OR TOWN <u>Clinton Mo</u> | | c. CITY OR TOWN <u>Clinton</u> | |
| c. LENGTH OF STAY (In this place) <u>5 days</u> | | d. STREET ADDRESS (If rural, give location) <u>Witzel Hospital</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Witzel Hospital</u> | | d. STREET ADDRESS (If rural, give location) <u>Witzel Hospital</u> | |
| 3. NAME OF DECEASED a. (First) <u>WILLIAM</u> | | b. (Middle) <u>DEAN</u> | |
| c. (Last) <u>CAMPBELL</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>July 21-49</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>infant</u> | 8. DATE OF BIRTH <u>July 16-49</u> |
| 9. AGE (In years last birthday) <u>5</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13a. FATHER'S NAME <u>William H Campbell</u> | | 13b. MOTHER'S MAIDEN NAME <u>Helia Woirhaye</u> | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | |
| 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>William H Campbell</u> | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | 19. ADDRESS <u>Rich</u> | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>surgery to establish anus and rectum</u> | | 7/16/49 | |
| DUE TO (c) | | 7592 | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION <u>7/16/49</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 19b. MAJOR FINDINGS OF OPERATION <u>No anus or Rectum</u> | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, warehouse, etc.) | |
| 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>7/16</u> , 19 <u>49</u> , to <u>7/21</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>7/21</u> , 19 <u>49</u> , and that death occurred at <u>2 P. m.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE <u>W. J. Brown</u> (Degree or title) <u>DO</u> | | 23b. ADDRESS <u>Clinton Mo</u> | |
| 23c. DATE SIGNED <u>7/21/49</u> | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>July 22-49</u> | |
| 24c. NAME OF CEMETERY OR CREMATORY <u>Witch Cem</u> | | 24d. LOCATION (City, town, or county) (State) <u>Witch Mo</u> | |
| DATE REC'D BY LOCAL REG. <u>July 21-49</u> | | REGISTRAR'S SIGNATURE <u>Florence Adair</u> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Brown</u> | | ADDRESS <u>Witch Mo</u> | |

RECEIVED

District Health Officer No. 71

District File Number 6-49-183

Date Filed 7-25-49

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 _____

not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed R. R. Kenney

Licensed Embalmer No. 3099

P. O. Address Clinton md

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.