

No. 306
10-48

9971

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11655**

FILED APR 7 1952

BIRTH NO. _____ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 3071 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, address before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>	
b. CITY OR TOWN <u>Slater</u>	c. LENGTH OF STAY (In this place) <u>10 years</u>	c. CITY OR TOWN <u>Slater</u> <u>0971</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location)		d. STREET ADDRESS (If rural, give location) <u>622 North Central St</u>	
3. NAME OF DECEASED a. (First) <u>CLARENCE</u> b. (Middle) <u>CLAUDE</u> c. (Last) <u>CAMPBELL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March-28-1952</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>June-11-1875</u>
9. AGE (In years last birthday) <u>76-7-17</u>		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Retired Mail Service: Civil Service</u>	11. BIRTHPLACE (State or foreign country) <u>Green Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Daniel S. Campbell</u>	13b. MOTHER'S MAIDEN NAME <u>Flora Griffin</u>
14. NAME OF HUSBAND OR WIFE <u>Maude Estelle Campbell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NUMBER <u>Retired</u>
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Clarence C Campbell</u>		18. ADDRESS <u>151 X</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.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Father's Neurosyphilis</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Post influenza</u>			
DUE TO (c) <u>AD ?</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>	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>3-7-52</u> , 19 <u>52</u> , to <u>20/28</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>2-26-52</u> , and that death occurred at <u>3:00 P</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>M. B. Leaton, M.D.</u>		23b. ADDRESS <u>506 N. Main St Slater Mo</u>	23c. DATE SIGNED <u>3/12/52</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3-30-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>High Creek Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>6 miles South East Slater Mo</u>
DATE REC'D BY LOCAL REG. <u>3/31/52</u>	REGISTRAR'S SIGNATURE <u>Mrs. Earl C. Metz</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. Jones</u> ADDRESS <u>Slater Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

APR 27 1962

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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 _____

_____ Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed James E. Jones
Licensed Embalmer No. 3143
P. O. Address Slater M

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.