No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED APR 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12507

BIRTH NO. 3101-55 REG. DIST. NO. 175 PRIMARY REG. DIST. NO. 4277 Registrar's No. 30

1. PLACE OF DEATH
a. COUNTY: Lawrence
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Verona Springriver
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Verona Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Barry
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Monett 0051
d. STREET ADDRESS (If rural, give location): 4 Mile South

3. NAME OF DECEASED (Type or Print): a. (First) Michael b. (Middle) Eugene c. (Last) Campbell

4. DATE OF DEATH (Month) 1 (Day) 21 (Year) 55

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant 0

8. DATE OF BIRTH: Jan. 21-1955

9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 1 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lawrence 0

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Bernard Campbell

13b. MOTHER'S MAIDEN NAME: Lenora Lipka

14. NAME OF HUSBAND OR WIFE: Infant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no. (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: Bernard Campbell, Monett

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Prolonged labor

DUE TO (c) Prematurely ruptured amniotic sac.

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: 7610

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 20, 19 55, *to* Jan. 20, 19 55 *that I last saw the deceased alive on* Jan. 20, 19 55, *and that death occurred at* 10:45 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): F. Avery Watson D.O.

23b. ADDRESS: Verona, Mo.

23c. DATE SIGNED: 1-22-55

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 1/22/55

24c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

24d. LOCATION (City, town, or county) (State): Aurora, Mo.

DATE REC'D BY LOCAL REG. 4-16-1955

REGISTRAR'S SIGNATURE: Ora M. Nett

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Oscar L. Marsh, Aurora, Mo.

(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

was not Embalmed, Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Oscar L. Marsh

Licensed Embalmer No. 3812

P. O. Address Pierce 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.