

Health,
& Welfare
Public
Service

FILED AUG 20 1958

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 299

5. 300
1-57

941

Every entry, except those in any standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BONNE TERRE</u> Inside Limits Year <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>BONNE TERRE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u> Length of stay in 1b | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED First Middle Last <u>DANNY J. CAMPBELL</u> | | | 4. DATE OF DEATH Month Day Year <u>AUG. 4 1958</u> |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>AUG. 4 1958</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Bonne Terre Hosp. MO</u> |
| 13a. FATHER'S NAME <u>CHARLES CAMPBELL</u> | | 13b. MOTHER'S MAIDEN NAME <u>MONA SWAIN</u> | 14. NAME OF HUSBAND OR WIFE <u>NONE</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT Address <u>Charles Campbell, Leadington, Mo</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atalectasis lungs</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>5 mo gestation</u> 7625 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |
| 21. I attended the deceased from <u>Aug 4, 1958</u> to <u>Aug 4, 1958</u> and last saw ^{him} alive on <u>Aug 4, 1958</u> Death occurred at <u>4:00 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>D. O. Gaillet M.D.</u> | | 22b. ADDRESS <u>Neosho, Mo</u> | 22c. DATE SIGNED <u>8-4-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>AUG. 4, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u> | 23d. LOCATION (City, town, or county) (State) <u>Leadington, MO.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Raymond Caldwell and Sons Flat River, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Aug. 4, 1958</u> | 26. REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u> |

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
Signature of Student Embalmer

Signed *R. Caldwell*

Licensed Embalmer No. *2531*
P. O. Address *Flat River, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.