

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038539  
STATE FILE NUMBER

FILED NOV 5 1958 Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 38

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <b>Slater</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Slater</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>613 Maple</b>		Length of stay in 1b <b>5 Months</b>	
d. STREET ADDRESS <b>613 Maple</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Azzie</b> Middle <b>(None)</b> Last <b>Campbell</b>			4. DATE OF DEATH Month <b>10</b> Day <b>31</b> Year <b>58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-24-1867</b>		9. AGE (In years last birthday) <b>91</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>Miami, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joe Campbell</b>			14. MOTHER'S MAIDEN NAME <b>Elvira DK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Rachel Sharon Slater, Mo.</b>			

18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
DUE TO (b) <b>Cerebral hemorrhage</b>			
DUE TO (c) <b>Essential hypertension</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X</b>			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

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 <b>11 A.M.</b> Month <b>11</b> Day <b>2</b> Year <b>58</b>			

20d. INJURY OCCURRED WHILE AT WORK <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 <b>Slater, Mo.</b>	COUNTY <b>Mo.</b>	STATE
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21. I attended the deceased from **Sept. 1955** to **Oct. 31, 1958** and last saw him alive on **Oct. 25, 1958**. Death occurred at **11 A.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>C. A. McBurney, M.D.</b>	22b. ADDRESS <b>Slater, Mo.</b>	22c. DATE SIGNED <b>11-1-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-2-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah</b>	23d. LOCATION (City, town, or county) (State) <b>Slater Mo.</b>
24. FUNERAL DIRECTOR <b>Haines Funeral Home Slater, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>11-1-58</b>	26. REGISTRAR'S SIGNATURE <b>Mo. E. C. Metz</b>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service, 977, 00, -56, diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
C. A. McBurney

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Walter J. Haines*  
Licensed Embalmer No. 4

P. O. Address *Flat*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.