

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010137

STATE FILE NUMBER

Health,
Welfare
Public
Service

300
1-57

FILED APR 2 1959 Registration District No. 700 Primary Registration District No. _____ Registrar's No. 56

1. PLACE OF DEATH a. COUNTY <u>MACON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> COUNTY <u>MACON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bevier</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bevier 06100</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____		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 (Type or print) First Middle Last <u>LENA CAMPBELL</u>			4. DATE OF DEATH Month Day Year <u>3-18-59</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Metropolis Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Hewitt</u>		13b. MOTHER'S MAIDEN NAME <u>Georgeann Rice</u>	14. NAME OF HUSBAND OR WIFE -
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>6</u>	17. INFORMANT <u>Nathan Clark</u> Address <u>Chicago Ill</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>Cerebral Vascular Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>4221</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Malnutrition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 COUNTY STATE	
21. I attended the deceased from _____ to <u>3/18/59</u> and last saw her alive on <u>3/18/59</u> Death occurred at <u>2:30 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James E. Campbell</u> (Degree or title)		22b. ADDRESS <u>Macoy Mo</u>	22c. DATE SIGNED <u>3/24/59</u>
23a. BURIAL, CREMATION, REBURYAL (Specify)	23b. DATE <u>3-22-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West Oakwood P</u>	23d. LOCATION (City, town, or county) (State) <u>Bevier Mo</u>
24. FUNERAL DIRECTOR <u>W. S. Edwards</u>		ADDRESS <u>Bevier Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3/31/59</u>
26. REGISTRAR'S SIGNATURE <u>Ruth McNeely</u>			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only 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

Date Filed... 4-1-59

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 *W. J. Edwards*

Licensed Embalmer No. *1961* ..
P. O. Address *Bevin*

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.