

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012059

STATE FILE NUMBER

FILED MAR 17 1959

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 55

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|---|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Vernon | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Vernon | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Nevada | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Nevada | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 518 East Austin | | Length of stay in lb 2 years | d. STREET ADDRESS (If outside, give location) 518 E. Austin | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ESTELIA Middle MAY Last CAMPBELL | | | 4. DATE OF DEATH Month February Day 23 Year 1959 | | |
| 5. SEX Fm | 6. COLOR OR RACE Wh | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 4, 1874 | 9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | 11. BIRTHPLACE (City and state or country) Kansas City, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME John D. Grimes | | 13b. MOTHER'S MAIDEN NAME Mary Watt | | 14. NAME OF HUSBAND OR WIFE Walter Campbell, Deceased | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 496-05-8154D | 17. INFORMANT Harold Cadman North Kansas City 16, Missouri Address 7004 N. Walnut | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency R#12 DUE TO (b) arterio-sclerosis & atherosclerosis DUE TO (c) un known PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1.2.2.1 | | | | | INTERVAL BETWEEN ONSET AND DEATH un known |
| 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.) ITEM 22c CORRECTED BY AFFIDAVIT OF Physician 3-23-59 | | | |
| 20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> 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 7-17-58 to 2-22-59 and last saw him alive on 2-21-59 Death occurred at 4 A. M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) F.A. Martin M.D. | | | 22b. ADDRESS Nevada Mo. | | 22c. DATE SIGNED 2-26-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1959 February 25 | 23c. NAME OF CEMETERY OR CREMATORY Newton Burial Park | | 23d. LOCATION (City, town, or county) (State) Nevada Missouri | |
| 24. FUNERAL DIRECTOR Ferry Funeral Home Nevada, Missouri | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. 3-11-1959 | 26. REGISTRAR'S SIGNATURE (Anna) E. Ferry |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *L. Douglas Ferry*

Licensed Embalmer No. *4966*

P. O. Address *Memphis*

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.