

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012712

STATE FILE NUMBER

FILED APR 16 1959

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 31

300
1-57

1. PLACE OF DEATH a. COUNTY <u>CLINTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLINTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAMERON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CAMERON</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>Home</u>		Length of stay in 1b	d. STREET (If outside, give location) ADDRESS <u>425 1/2 Chestnut.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALFRED JULIAN CAMPBELL</u>			4. DATE OF DEATH Month Day Year <u>April 11 - 1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 4. 1904</u>
9. AGE (In years last birthday) <u>55</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRUGGIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DRUG STORE</u>	11. BIRTHPLACE (City and state or country) <u>ERFORD OKLA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>J. H. CAMPBELL</u>	
13b. MOTHER'S MAIDEN NAME <u>ELIZABETH HILL</u>		14. NAME OF HUSBAND OR WIFE <u>MABEL CAMPBELL</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>4260</u>	
17. INFORMANT <u>Mrs. Mabel Campbell</u>		Address <u>CAMERON 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>acute Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerotic Heart Disease</u>			Determined
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>obesity chronic cholecystitis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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"/> AT WORK <input type="checkbox"/> NOT WORK		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>4-8-59</u> to <u>4-11-59</u> and last saw her/him alive on <u>4-8-59</u> Death occurred at <u>300 A</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. H. Wetherston MD</u>		22b. ADDRESS <u>Cameron Mo</u>	
22c. DATE SIGNED <u>4-11-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-13-59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>PARSONS Kansas.</u>	
24. FUNERAL DIRECTOR <u>DeMoss CRUNK</u>		ADDRESS <u>CAMERON MO</u>	
25. DATE RECD. BY LOCAL REG. <u>4-11-59</u>		26. REGISTRARY SIGNATURE <u>Francis D Crawford</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

STATEMENT BY LICENSED EMBALMER

APR 28 1955

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 *Leo M. Cameron*

Licensed Embalmer No. *2533*

P. O. Address *Leamington*

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.