

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000033

FILED VS JAN 18 1960 2

Registration District No. _____ Primary Registration District No. 5019 Registrar's No. 6

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ANDREW</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ROCHESTER TOWNSHIP</u> Length of stay in lb <u>2 months</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SHADY LAWN</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>ANDREW</u> c. CITY OR TOWN <u>WHITESVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 <u>MARY</u> Middle <u>BELLE</u> Last <u>CAMPBELL</u>			4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1960</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-71</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>Delaware County, Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>HENRY HARMON</u>		13b. MOTHER'S MAIDEN NAME <u>unk</u>		14. NAME OF HUSBAND OR WIFE <u>ASHEL 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. - - -		17. INFORMANT Address <u>Fay Campbell, Rosendale, 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>Carcinoma of the left parotid gland with metastasis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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 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 <u>8-30-54</u> to <u>1-6-60</u> and last saw her live <u>live</u> on <u>12-21-59</u> Death occurred at <u>9:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased or title) <u>Warren C Baker M.D. Savannah, Mo.</u>			22b. ADDRESS <u>Savannah, Mo.</u>		22c. DATE SIGNED <u>1-8-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>1-10-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Whitesville Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Whitesville, Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>BREIT & HAWKINS SAVANNAH</u>			25. DATE RECD. BY LOCAL REG. <u>1-12-60</u>		26. REGISTRAR'S SIGNATURE <u>Lillian Sparks</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 23 1960

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Severnack

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