URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-037234

STATE FILE NUMBER

FILED VS SEP 2 0 1960

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 193

NDED

1. PLACE OF DEATH
a. COUNTY Vernon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township
Length of stay in 1b: 1 yr 4 mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Hosp. # 3
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jasper
c. CITY OR TOWN Webb City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) Unknown
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Mable Middle M. Last Campbell
4. DATE OF DEATH: Month September Day 2 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 3-12-92
9. AGE (last birthday): 68
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (City and state or country): Barry Co., Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: John Smith
13b. MOTHER'S MAIDEN NAME: Emma Henderson
14. NAME OF HUSBAND OR WIFE: Unknown (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 494-18-7515
17. INFORMANT: Records of State Hospital # 3, Nevada, Mo. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Vessel Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Atheromatous Sclerosis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I: Chronic Brain Syndrome Associated with Circulatory Disturbance, with Behavioral Reaction.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT 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 May 18, 1959, to 9-2-60 and last saw her alive on 9-2-60
Death occurred at 9:27 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) E. Allen Pickens, M.D.
22b. ADDRESS St. Hosp. # 3, Nevada, Mo.
22c. DATE SIGNED 9-2-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9-6-60
23c. NAME OF CEMETERY OR CREMATORY: local
23d. LOCATION (City, town, or county) (State): Webb City, Missouri
24. FUNERAL DIRECTOR: Ferry Funeral Home, Nevada, Missouri ADDRESS
25. DATE RECD. BY LOCAL REG.: 9-17-1960
26. REGISTRAR'S SIGNATURE: Arnal E. Ferry

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed R. Hughes Ferr

Signature of Student Embalmer

Licensed Embalmer No. 4960

P. O. Address Kenada

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