

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-018820

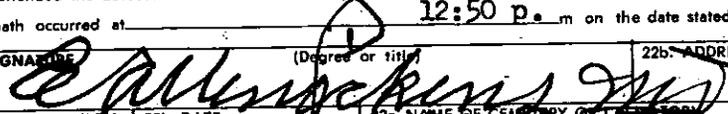
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 69

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED MAY 7 1963	
1. PLACE OF DEATH a. COUNTY <u>Vernon</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>	Length of stay in 1b <u>6mo.-6 da.</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS (If outside, give location) <u>324 N. Washington</u>	
3. NAME OF DECEASED First Middle Last (Type or print) <u>Clyde Golden Campbell</u>	
4. DATE OF DEATH Month Day Year <u>April 28 1963</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>1-1-1879</u>
9. AGE (last birthday) <u>84</u>	
IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>
11. BIRTHPLACE (City and state or country) <u>Locust Hill, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Ralph Martin Campbell</u>	13b. MOTHER'S MAIDEN NAME <u>Alice Jane Golden</u>
14. NAME OF HUSBAND OR WIFE <u>Widowed.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>
17. INFORMANT Address <u>Hospital Records-</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>Broncho-Pneumonia</u>	
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>	
DUE TO (c) <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome</u> <u>Associated With Senile Brain Disease.</u>	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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. s.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>Oct. 22, 1962</u> to <u>Apr. 28, 1963</u> and last saw her/him alive on <u>Apr. 28, 1963</u> Death occurred at <u>12:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) 	22b. ADDRESS <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>
22c. DATE SIGNED <u>4-28-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>4-31-63</u>
23c. NAME OF CEMETERY OR CREMATOR <u>Shuffield</u>	
23d. LOCATION (City, town, or county) (State) <u>Arcadia Kansas</u>	
24. FUNERAL DIRECTOR <u>Berkey Funeral Home</u>	ADDRESS <u>Arcadia, Kans</u>
25. DATE RECD. BY LOCAL REG. <u>4-29-1963</u>	26. REGISTRAR'S SIGNATURE 

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

10201  
52801

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**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 N. J. - Moorehan

Licensed Embalmer No. 3616

P. O. Address Aracadia, Kansas

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.