

Dr. Brown  
**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-63-019699**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 729

**FILED MAY 20 1963**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
 Rev. 4/59

1 0397

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>63 YRS.</b>	c. CITY OR TOWN <b>SPRINGFIELD</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HANDLEY HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>444 SOUTH AVE.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MABELLE MARIE CAMPBELL</b>			4. DATE OF DEATH Month Day Year <b>MAY 13 1963</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/2/99</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FILE CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FRISCO R.R.</b>	9. AGE (last birthday) <b>63</b> IF UNDER 1 YEAR   IF UNDER 24 HR Months   Days   Hours   Min.
11. BIRTHPLACE (City and state or country) <b>HIGHLANDVILLE, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>RICHARD HUNTLEY CAMPBELL</b>		13b. MOTHER'S MAIDEN NAME <b>IDA MAE BROCKMAN</b>	
14. NAME OF HUSBAND OR WIFE <b>J.R. CAMPBELL</b>		Address <b>SPRINGFIELD, MO.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>J.R. CAMPBELL</b>		Address <b>SPRINGFIELD, MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral apoplexy</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 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 a.m. p.m. Month, Day, Year			
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>5/10/63</u> to <u>5/13/63</u> and last saw him alive on <u>5/13/63</u> Death occurred at <u>5:20 P.M.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Lyman D. Brown M.D.</b>		22b. ADDRESS <b>311 1/2 College</b>	22c. DATE SIGNED <b>5/15/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5/17/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HAZELWOOD</b>	23d. LOCATION (City, town, or county) <b>SPRINGFIELD, MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>5-17-63</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b> <i>EW</i>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

MAY 23 1963

Permit 5-14-63

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 Lucretia T. Shively

Licensed Embalmer No. 4815

P. O. Address Springhill, Mo.

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.