

**FILED MAY 26 1945**

Registration District No. **26185**

Primary Registration District No. **4444**

Registrar's No. **9**

**1. PLACE OF DEATH:** Ray

(a) County Ray

(b) City or town Camden, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None **1**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: All His Life **None**  
In hospital or institution. (Specify whether years, months or days)

In this community None

**3. (a) PRINT FULL NAME** JOSEPH CAMPBELL

3. (b) If veteran, name war: None

3. (c) Social Security No. None

4. Sex Male 9

5. Color or race Black

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lulu Johnson

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: January 15 **1861.**  
(Month) (Day) (Year)

8. AGE: Years 64 Months 2 Days 20 If less than one day  
hr. min.

9. Birthplace: Ray Co. Mo. **0**  
(City, town, or county) (State or foreign country)

10. Usual occupation: Rt. Coal Miner

11. Industry or business: Peter Campbell

12. Name: North Carolina **1**

13. Birthplace: Unknown **9**  
(City, town, or county) (State or foreign country)

14. Maiden name: Unknown

15. Birthplace: Unknown

16. (a) Informant: Lulu Campbell

(b) Address: Camden, Mo.

17. (a) Burial (b) Date thereof: 4-7-45.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Camden, Mo.

18. (a) Signature of funeral director: W. B. Brothers

(b) Address: Richmond, Mo.

19. (a) 4/19/45 (b) Dr. W. H. Henson  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Ray **89**

(c) City or town Camden, Mo. **1**  
(If outside city or town limits, write "RURAL")

(d) Street No. City Limits **1**  
(If rural, give location)

(e) Citizen of foreign country? No **1** (Yes or No)  
If yes, name country: U.S.A.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 4th.  
1945. year hour 1 minute 30 a.m.

21. I hereby certify that I attended the deceased from March  
1945 to April 3, 1945  
that I last saw him alive on April 3, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage

Due to: arterio sclerosis

Other conditions: None  
(Include pregnancy within 3 months of death)

Major findings: None  
Of operations: None

Of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? Yes (Specify type of place) \_\_\_\_\_  
(e) Means of injury: \_\_\_\_\_

23. Signature: J. B. Fay (M. D. or other) MD  
Address: Richmond, Mo. Date signed: 4-4-45

1228

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

9/4/43

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 \_\_\_\_\_ Registered Apprentice No. \_\_\_\_\_ working under my personal supervision.

Signed *Brother - Quest Funeral Home*  
*Louis Quest*

Licensed Embalmer No. *4096*

P. O. Address *Richmond, 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 this body is not embalmed, fact should be so stated above.