

MAY 25 1934

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Ray  
Township Orwich  
City Orwich (No. \_\_\_\_\_)

Registration District No. 743  
Primary Registration District No. 4445

File No. 10111  
Registered No. 4  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Wilina Lee Campbell

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Infant</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Infant</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>3/19/1933</u>		
7. AGE - YEARS <u>1</u>	MONTHS <u>0</u>	DAYS <u>8</u>
		IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Infant</u>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
	10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Richmond Mo  
(STATE OR COUNTRY) Ray Co

13. NAME William J. Campbell

14. BIRTHPLACE (CITY OR TOWN) Lawson  
(STATE OR COUNTRY) Ray Co Mo

15. MAIDEN NAME Effie Claypool

16. BIRTHPLACE (CITY OR TOWN) Knoxville  
(STATE OR COUNTRY) Ray Co Mo

17. INFORMANT William J. Campbell  
(ADDRESS) Orwich Mo

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Berry Slope East Richmond DATE 3/28 1934

19. UNDERTAKER C. V. Gibson  
(ADDRESS) Orwich Mo

20. FILED 5-8 1934 Orwich Registrar.

V MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/27 1934

22. I HEREBY CERTIFY, That I attended deceased from March 27, 1934, to March 27, 1934

I last saw her alive on Mar 27, 1934 Death is said to have occurred on the date stated above, at 2 P. m.

The principal cause of death and related causes of importance were as follows:

Date of onset \_\_\_\_\_

meningitis  
10724  
10724

Other contributory causes of importance:  
Bronchial Pneumonia

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_ 3-27-34

What test confirmed diagnosis? clinical Was there an autopsy? no

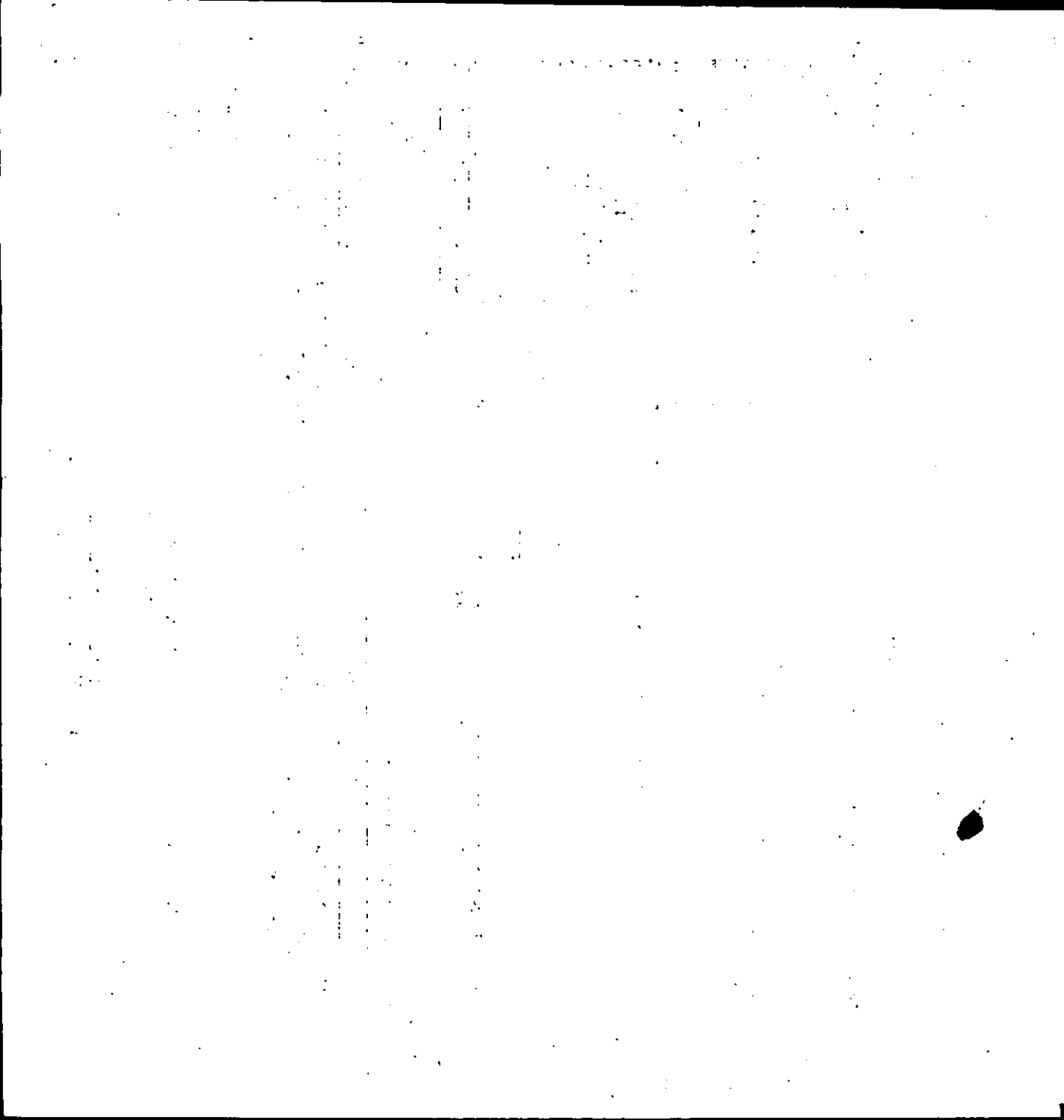
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_

(Signed) [Signature] \_\_\_\_\_, M. D.  
(Address) Orwich Mo



REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**  
 County Ray Registration District No. 943  
 Township \_\_\_\_\_ Primary Registration District No. 4442  
 City Orwick (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME** William Lee Campbell  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

10111  
 File No. \_\_\_\_\_  
 Registered No. 4

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

**3. SEX** M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** single

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** \_\_\_\_\_

**6. DATE OF BIRTH (MONTH, DAY, AND YEAR)** \_\_\_\_\_

<b>7. AGE</b>	<b>YEARS</b>	<b>MONTHS</b>	<b>DAYS</b>	<b>If LESS than 1 day, hrs. or min.</b>
			<u>8</u>	

**8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.** \_\_\_\_\_

**9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.** \_\_\_\_\_

**10. Date deceased last worked at this occupation (month and year)** \_\_\_\_\_

**11. Total time (years) spent in this occupation** \_\_\_\_\_

**12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** \_\_\_\_\_

**FATHER**

**13. NAME** \_\_\_\_\_

**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** \_\_\_\_\_

**MOTHER**

**15. MAIDEN NAME** \_\_\_\_\_

**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** \_\_\_\_\_

**17. INFORMANT (ADDRESS)** \_\_\_\_\_

**18. BURIAL, CREMATION, OR REMOVAL**  
 PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

**19. UNDERTAKER (ADDRESS)** Orwick, mo

**20. FILED** 5/8 1934 Orwick Registrar

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)** 3/27 1934

**22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.**  
 I last saw h..... alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
meningitis  
following broncho pneumonia,  
(Pneumococcus meningitis)  
 Other contributory causes of importance: 1070  
Broncho pneumonia

**Name of operation** \_\_\_\_\_ **Date of** \_\_\_\_\_

**What test confirmed diagnosis?** \_\_\_\_\_ **Was there an autopsy?** \_\_\_\_\_

**23. If death was due to external causes (violence), fill in also the following:**  
 Accident, suicide, or homicide? \_\_\_\_\_ **Date of injury** \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

**Manner of injury** \_\_\_\_\_  
**Nature of injury** \_\_\_\_\_

**24. Was disease or injury in any way related to occupation of deceased?** \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) Orwick, mo, M. D.  
 (Address) Orwick, mo

SUPPLEMENTARY

11101

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McLaugh, M. D.,  
Special Agent,  
Jefferson City, Mo.

10111

Ray

4

Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Wilma Lee Campbell

Died at: Orrach on Mar. 27-1934

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Color or race F Single, married, widowed or divorced: S

Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Place of birth (State or country) \_\_\_\_\_

Place of father (State or country) \_\_\_\_\_

Place of mother (State or country) \_\_\_\_\_

Principal cause of death: Meningitis

Other contributory causes of importance Bronchial pneumonia

Time of operation none Date of 2-27-34

Test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

Death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Character of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician J. S. Pate

Address of physician Orrach

Signature of Registrar J. S. Pate Date filed 5/8/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 743

Primary-Reg. Dist. No. 4445-

E. T. McLaugh

Special Agent.

COMMUNICATIONS SECTION  
U.S. AIR FORCE

1011

UNCLASSIFIED

1000

TO: SAC, [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]