

National Office of Vital Statistics
FILED DEC 17 1947

Registration District No. **799**

Primary Registration District No. **5424**

1. PLACE OF DEATH

(a) County **Dunklin Rural**

(b) City or town **Campbell R. R. #1 Union Twp**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **Home**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community **most of life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Dunklin 35**

(c) City or town **Campbell R. R. #1**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Laura Belle Vincent**

3. (b) If veteran, name war **none**

3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **white**

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

6. (b) Name of husband or wife **James Vincent**

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

7. Birth date of deceased **unknown**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

Unknown br. min.

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

10. Usual occupation **Housework**

11. Industry or business _____

12. Name **unknown** 9

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

14. Maiden name **unknown**

15. Birthplace **unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Vernie Vincent**

(b) Address **Campbell, Mo. R. 1**

17. (a) **Burial** (b) Date thereof **11-24-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Vincent Cemetery**

18. (a) Signature of funeral director **Landers Funeral Home**

(b) Address **Campbell Missouri**

19. (a) **12/1/1947** (b) **Mrs. Belle Campbell**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **22nd**
year **1947** hour _____ minute **9:50 p.m.**

21. I hereby certify that I attended the deceased from **11/20**, 1947 to **11/29**, 1947.
that I last saw her alive on **11/22**, 1947
and that death occurred on the date and hour stated above.

In the cause of death **Acute Pneumonia**

Duration **10 days**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN _____

Major findings: Of operations _____

Of autopsy **108**

Underline the cause of 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? _____ (Specify type of place)

While at _____ (a) Means of injury _____

23. Signature **W. J. Rutledge** (M. D. or other) **MD**

Address **Campbell Mo** Date signed **11/26/47**

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 1217-1528

Date Filed 12-11-42

FEB 6 1953

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 Not Embalmed

Licensed Embalmer No.....

P. O. Address.....

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.