

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

Do not use this space.

31575

1. PLACE OF DEATH

County..... Registration District No. 791 File No. 8910
 Township..... Primary Registration District No. 1003 Registered No.
 City St. Louis Mo. (No. Sanitarium) St. Ward)

2. FULL NAME

Julia Campbell
 (a) Residence. No. 1854 Cass St. 13 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 15 yrs. + mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 21, 1862

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	64	11	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dressmaker
 (b) General nature of industry, business, or establishment in which employed (or employer) Unknown
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kirkwood
 (STATE OR COUNTRY) Missouri

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) " " " "
	12. MAIDEN NAME OF MOTHER " " " "
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) " " " " " "

14. INFORMANT Joseph H. Hobbie
 (Address) 5300 Akers

15. FILED 501-5 1881 Marb Starke
 19. 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/4/27 19

I HEREBY CERTIFY, That I attended deceased from 9/28/27, 19, to 10/4/27, 19, that I last saw him alive on 9/28/27, 19, and that death occurred, on the date stated above, at 7:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis

95C
 CONTRIBUTORY (SECONDARY) 908
 (duration) yrs. 7 mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH. No. DATE OF.....
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Joseph H. Hobbie, M.D.
10/4/27, 19 (Address) 5300 Akers

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Peter's Cemetery DATE OF BURIAL 10-6 1927

20. UNDERTAKER Geo. L. Pleitach ADDRESS 5966 Easton

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

