

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

Do not use this space.

7026

1. PLACE OF DEATH

County..... Registration District No. 791
 Township St. Louis Primary Registration District No. 1003
 City St. Louis City Hospital # 2 File No.
 Registered No. 1892 St. Ward)

2. FULL NAME

Jannie Campbell
 (a) Residence. No. 379 Talcott St. 9 Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid.
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF -

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-29-1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
64 9 19

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)..... no
 (STATE OR COUNTRY)

10. NAME OF FATHER George Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... no
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... no
 (STATE OR COUNTRY)

14. INFORMANT A. Helms Creath
 (Address) City Hospital #2

15. FILED 2:11 19 1930 REGISTRAR Walter C. Taylor

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/18/1930

17. I HEREBY CERTIFY, That I attended deceased from 2-17-30, 1930 to 2-18-30, 1930 that I last saw her alive on 2-18-30, 1930, and that death occurred, on the date stated above, at 10:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
 (duration) 1 yrs. - mos. - ds.

CONTRIBUTORY (SECONDARY) NO
 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? NO DATE OF.....

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) A. E. Stale, M. D.

*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 Greenwood Cemetery DATE OF BURIAL 2/23 1930

20. UNDERTAKER Walter C. Taylor ADDRESS 4107 Penney

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.

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