

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

Do not use this space.

7263

1. PLACE OF DEATH

County.....
Township.....
City.....
Registration District No. **791**
Primary Registration District No. **1003**
No. **Resonance Hospital**

File No.....
Registered No. **2141**
St..... Ward.....

2. FULL NAME

Phillis Jean Campbell
(a) Residence. No. **Missouri Hotel** Ward **25**
(Usual place of abode) **11th & Locust St.** (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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **January 8 - 1925**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 1 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **None**
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Canada**

10. NAME OF FATHER **Alfred A. Campbell**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Alabama**

12. MAIDEN NAME OF MOTHER **Kathryn Marie King**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

14. INFORMANT (Address) **Alfred A. Campbell Missouri Hotel**

15. FILED **Jan 28 1930** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 28th 1930**

17. I HEREBY CERTIFY, That I attended deceased from **2-18**, 19**30**, to **2-28**, 19**30** that I last saw her alive on **2-27**, 19**30**, and that death occurred, on the date stated above, at **8:25** **A**.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia, Primary (Total)

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH **Missouri Hotel**

DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? **Physician's Certificate**

(Signed) **E. H. Kahleberg** M. D.

28, 19**30** (Address) **3720 Washington Blvd.**

*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 DATE OF BURIAL

La Glita Mo. **3/1 1930**

20. UNDERTAKER **Arthur Harnelly** ADDRESS **7039 Wash St.**

WRITE FULLY, 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.

Dr Kohler
3720 Washington

H-1