

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.

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

16907
Do not use this space.

**791
1008**

REC'D JUN 12 1939

1. PLACE OF DEATH

(a) County.....
 (b) Township.....
 (c) City ST. LOUIS MO
 (d) Street No. 1 Registration District No. 2
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (If nonresident, give city or town and State)

2. PRINT FULL NAME 514 MARIE CAMPBELL

(a) Residence, No. 1508 McCASLAND St. NR EAST ST. LOUIS ILL
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEM 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF EDW. CAMPBELL
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ABT 1897
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. ABT 42
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSE WIFE
 9. Industry or business in which work was done, as 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) MISS. 1

FATHER 13. NAME STEVE CLAYTON

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISS 9

MOTHER 15. MAIDEN NAME UNKNOWN

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

17. INFORMANT (ADDRESS) EDW. CAMPBELL 1508 McCASLAND E. ST. L. ILL

18. BURIAL, CREMATION OR REMOVAL PLACE E. St. Louis DATE 5/14 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. M. C. Green 3517 Lauder Ave.

20. FILED MAY 14 1939 J. D. Brudner Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-13-39 1939
 22. I HEREBY CERTIFY, That I attended deceased from 4-27, 1939, to 5-13, 1939
 I last saw her alive on 5-13, 1939. Death is said to have occurred on the date stated above, at 4:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Hypothyroidism
Degenerative heart disease
Decompensation mild
 +
 Other contributory causes of importance:
Thyroid crisis
post-operative

Date of onset 8-1-38

Name of operation Thyroidectomy Date of 5-11-39
 What test confirmed diagnosis? Basal Was there an autopsy? yes

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) F. R. Bradley, M. D.
 (Address) BARNES HOSPITAL

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 *A. M. Green*

Licensed Embalmer No. *1173*

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, above space should be left blank.