

7
1940
Clarence Campbell
30 6911

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12410

State File No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 8 1940
Registration District No. 784

Primary Registration District No. 111

Registrar's No. 476

1. PLACE OF DEATH:
(a) County Madison
(b) City or town Rack 1st
(c) Name of hospital or institution:
St. Mary's Hospital, St. Louis, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days 5 11

3. (a) PRINT FULL NAME Campbell, Dolores Jean
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____
4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 18 1932
(Month) (Day) (Year)

8. AGE: Years 8 Months _____ Days 17 If less than one day _____ hr. _____ min.
9. Birthplace Mt. View, Mo. (City, town, or county) (State or foreign country) Mo.

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 12. Name Clarence Campbell
13. Birthplace Mt. View, Mo. (City, town, or county) (State or foreign country) Mo.
14. Maiden name Dora Wiley
15. Birthplace Brushy Fork, Mo. (City, town, or county) (State or foreign country) Mo.

16. (a) Informant Clarence Campbell
(b) Address Mt. View, Mo.
17. (a) _____ (b) Date thereof March 9 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. View, Mo.
18. (a) Signature of funeral director Duncan Funeral Home
(b) Address Mt. View, Mo.
19. (a) MAP 7 1940 (b) DR. Meyer (Registrar's signature)
(Date received local registrar) (City, town, or county)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town Mt View (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) _____
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 6
year 1940 hour 3 minute 25 A.M.
21. I hereby certify that I attended the deceased from Nov. 25, 1939 to March 6, 1940
that I last saw her alive on March 5, 1940
and that death occurred on the date and hour stated above

Immediate cause of death Operation
Due to Cardiac Failure
Due to of for Brain tumor
Other conditions glionia
(Include pregnancy within 3 months of death)

Major findings: Tumor Carcinoma
Of operations Stomach
Of autopsy None

PHYSICIAN
Underline the cause to 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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address 4 Club Bldg Date signed _____

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

54A

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 Howard J. Rowland.

Licensed Embalmer No. 3114

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 27410
Registrar's No. 476

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH

(a) County St. Louis
(b) City or town Rich. H. to -
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community: _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Dolores J. Campbell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced -

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

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

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month Mar, day 6, year 40
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Operation for brain tumor, glioma (malignant)
Due to Cardiac failure

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

Major findings: Tumor cerebellum
Of operations glioma -
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. F. Coughlin (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

1940

S-12410