S. No. 2
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5-17-39
P I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 15 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16550

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4028

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

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Louis City Hosp #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 hours (Specify whether
In this community 33 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town St Louis 3
(If outside city or town limits, write "RURAL")

(d) Street No. 6239 Columbia
(If rural, give location)

(e) If foreign born, how long in U.S.A.? ~~[illegible]~~ years

3. (a) PRINT FULL NAME Horace L. Campbell 514

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Frances

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Dec (Month) 11 (Day) 1866 (Year)

8. AGE: Years 73 | Months 4 | Days 22 | If less than one day ___ hr. ___ min.

9. Birthplace Warsaw (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation Switchman - Retired 1

11. Industry or business Terminal R. R.

FATHER
12. Name Wm Campbell 0
13. Birthplace ——— (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name Ruth Phillips
15. Birthplace Warsaw (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Sarah Frances Campbell
(b) Address 6239 Columbia Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cem

18. (a) Signature of funeral director Witt Bros. L & U Co.
(b) Address 2929 S. Jefferson Ave.

19. (a) MAY 6 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3rd year 1940 hour 2 minute 50 A M.

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

Immediate cause of death Chronic Myocarditis Diabetes

Due to [signature]

Due to

Other conditions
(Include pregnancy within 3 months of death)

59

Major findings:
Of operations

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?
(Specify type of place)
While at work? (e) Means of injury 5

23. Signature [signature] (M. D. or other)
Address [illegible] Date signed 5-4-40

(Licensed Embalmer's Statement on Reverse Side)

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 Paul A. Shanklin, Registered Apprentice No. ..... working under my personal supervision.

Signed Paul A. Shanklin

Licensed Embalmer No. 3472

P. O. Address 2929 S. Jefferson

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.