

Registration District No. 13490

Primary Registration District No.....5984.....

Registrar's No. .... 11 .....

**1. PLACE OF DEATH:**

(a) County Washburn  
(b) City or town Swedeborg, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Swedeborg Temp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 (Specify whether in hospital or institution)  
In this community 1 year, month or day

3. (a) PRINT NAME WILLIAM FIGNATIELLO AMBELL

3. (b) If veteran, name war _____	3. (c) Social Security No. _____
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4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, 2 divorced, W widowed

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

7. Birth date of deceased. Feb 22 1957  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	86	10	7	hr. min.

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

10. Usual occupation..... FGY MEY

**11. Industry or business.**

12. Name: Josephine Campbell

FAT ( 13. Birthplace UNKNOWN TENN  
(City, town, or county) (State or foreign country)

14. Maiden name D. N. KADWIN

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

16. (c) Informant. Ess Campbell

(b) Address 1125 E. 1st St. St. Paul, MN

17. (a) Bureau (b) Date thereof 1-6-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eastview Cemetery

18. (a) Signature of funeral director: [Signature]

(b) Address 1000 1st St. NW

19. (a) 1-2/2-44 (b) Lehao McDodd  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Andrew  
(c) City or town Summerville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month JUN day 4th  
year 1944 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from Sept, 1943, to Jan 4, 1944,  
that I last saw him alive on Jan 4, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
INFLUENZA	2 wk

Due to: Penitentiary

Due to \_\_\_\_\_

Other conditions..... 732  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

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?.....

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

.....

While at work? ✓ (Specify type of place) (c) Means of injury

John C. F. ... 88

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**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.....

Licensed Embalmer No. 3198

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, fact should be so stated above.**