

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

8659

State File No. _____

FILED FEB 24 1944

Primary Registration District No. 6-27-3-45-117

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County St. Louis
(b) City or town Grant City, Mo.
(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 _____ (Specify whether _____)
In this community Life years, months or days

3. (a) PRINT FULL NAME

Elizabeth Alberta Campbell

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced, Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 20 1874
(Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Nevada Mo. U
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business _____

- MOTHER FATHER { 12. Name James Campbell
13. Birthplace Penn 1
(City, town, or county) (State or foreign country)
14. Maiden name Phyllis Reed
15. Birthplace Wilmington 9
(City, town, or county) (State or foreign country)

16. (a) Informant Vereta Reynolds

- (b) Address Long Beach, Calif.

17. (a) Burial (b) Date thereof 1-12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Grant City Cem.

18. (a) Signature of funeral director J. D. Duffee

- (b) Address Grant City, Mo.

19. (a) 1-20-44 (b) Arlene Seader
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County St. Louis 112
(c) City or town Grant City, Mo.
(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 1 day 11
year 1944 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from 12-20 1943 to 1-11 1944;
that I last saw him alive on 1-10 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Emphysema - 2 colon + liver 1 1/2

Due to _____

Due to _____

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

Major findings: Of operations ✓

Of autopsy no

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 J. D. Duffee M.D. (M. D. or other)

Address Grant City, Mo. Date signed 1-12-44

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Arch C. Dumble

Licensed Embalmer No. *3252*

P. O. Address. *Grant City, Mo.*

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.