V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 20 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12621

Registration District No. 318 Primary Registration District No. Registrar's No. 3383

1. PLACE OF DEATH:
(a) County ST LOUIS
(b) City or town ST LOUIS (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3231 LASALLE ST (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 25 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 12
(c) City or town ST LOUIS (If outside city or town limits, write "RURAL") 9
(d) Street No. 3231 LASALLE, ST. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Minnie Perkins Campbell.
3. (b) If veteran, name war NO
3. (c) Social Security No. NONE
4. Sex Female
5. Color or race Col.
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased — (Month) ABT (Day) 1881 (Year)
8. AGE: Years ABT 63 Months Days If less than one day hr. min.
9. Birthplace Centralia (City, town, or county) Ill. (State or foreign country)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace " " (City, town, or county) " (State or foreign country)

MOTHER
14. Maiden name " 9
15. Birthplace " " (City, town, or county) 9 (State or foreign country)

16. (a) Informant Clarence Ricks
(b) Address 4343 Cote Brilliante
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 4-12-44 (Month) (Day) (Year)
(c) Place: burial or cremation CENTRALIA, Ills
18. (a) Signature of funeral director Bernie Dove
(b) Address 3103 Washington
19. (a) APR 11 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7th year 1944 hour 11:55 minute 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.

	Duration
Immediate cause of death: Lobar Pneumonia	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations
Of autopsy

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
23. Signature Alfred Perry (M. D. or other)
Address Deputy Coroner Date signed 4/11/44

(Licensed Embalmer's Statement on Reverse Side)

Cousin

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 William Claude Gordon

Licensed Embalmer No. 3489

P. O. Address ~~146~~ 75 Aldine

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.