V. S. No. 2
100M—5-43
Rev. 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 DEC 27 1944

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 39220

Registrar's No. 10693

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2006 MAURY AVE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 30 YRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 17 17

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 2006 MAURY AVE
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country U

3. (a) PRINT FULL NAME JAMES M. CAMPBELL

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife THERESA

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

7. Birth date of deceased MARCH (Month) 10 (Day) 1877 (Year)

8. AGE: Years 67 Months 9 Days 5 If less than one day hr. min.

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

10. Usual occupation GRAIN INSPECTOR

11. Industry or business STATE OF MISSOURI

FATHER
12. Name ROBERT H. CAMPBELL
13. Birthplace MISSOURI (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ANN SHOCKLEY
15. Birthplace MISSOURI (City, town, or county) (State or foreign country)

16. (a) Informant MARIE CAMPBELL
(b) Address 2006 MAURY AVE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12 17 44 (Month) (Day) (Year)
(c) Place: burial or cremation BLAND MO

18. (a) Signature of funeral director KRIEGSHAUSER
(b) Address 4228 SO. KINGSHIGHSWAY

19. (a) DEC 15 1944 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 15
year 1944 hour 7 AM minute M.

21. I hereby certify that I attended the deceased from Oct. 27, 1943, 19 to Dec 15, 1944
that I last saw him alive on Oct. 27, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to Hypertensive myocarditis - chronic

Due to

Other conditions
(Include pregnancy within 3 months of death)

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

23. Signature Dr. Harry G. Giedeker M.D. (M. D. or other)
Address 634 N. Grand Date signed 12/15/44

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Calvin D. McDermott

Licensed Embalmer No. 3024

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.