S. No. 2
OM—5-43
v. 5-17-39
I X36671

#39754

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 28 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7560

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2575

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

1. PLACE OF DEATH:

(a) County

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

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

(d) Length of stay: In hospital or institution 6 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")

(d) Street No. 4053 Washington Blvd.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Annie Campbell

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased October (Month) 15 (Day) 1869 (Year)

8. AGE: Years 75 Months 5 Days 2 If less than one day hr. min.

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

10. Usual occupation Cook

11. Industry or business

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

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

16. (a) Informant Mrs. Murray
(b) Address 4053 Washington Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) MAR 20 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17th year 1945 hour 1:05 minute A. M.

21. I hereby certify that I attended the deceased from 3/9/45, 19, to 3/17/45, 19; that I last saw her alive on 3/17/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Cecum

Due to

Due to

Other conditions Renal arteriosclerosis
(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 E. W. Cochrane (M. D. or other)

Address 1515 Lafayette Date signed 3/17/45

(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.....

Licensed Embalmer No.....

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.