

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42079**
Registrar's No. **11334**

FILED JAN 13 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis MO		c. CITY (If outside corporate limits, write RURAL and give township) St Louis MO 2259	
c. LENGTH OF STAY (in this place)		d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital	
d. STREET ADDRESS 1619 Chestnut St.			

3. NAME OF DECEASED (Type or Print) Baxter Campbell	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Dec. 29 1950
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5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Not known 1915	9. AGE (In years) (Month) (Day) (Hour) (Min.) 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saboteur	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME John Campbell	13b. MOTHER'S MAIDEN NAME Not known	14. NAME OF HUSBAND OR WIFE Daisy Campbell
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Daisy Campbell	ADDRESS 1619 Chestnut
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH Undet.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis		
	DUE TO (c) Undetermined		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 321X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from **12-22**, 19 **50**, to **12-29**, 19 **50**, that I last saw the deceased alive on **12-29**, 19 **50**, and that death occurred at **5:45pm.**, from the causes and on the date stated above.

22a. SIGNATURE Lorenzo W Harris	(Degree or title) M. D.	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 1-4-51
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 1-3-51	24c. NAME OF CEMETERY OR CREMATORY Oak Dale Cem	24d. LOCATION (City, town, or county) (State) St Louis MO
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DATE REC'D BY LOCAL OFFICE JAN 5 1951	REGISTRAR'S SIGNATURE J. B. Carsten	25. FUNERAL DIRECTOR'S SIGNATURE A. H. Beal	ADDRESS 2626 Lucas
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WRITE PLAINLY—USING 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

working under my personal supervision.

Student Embalmer No.....

Signed

Arthur P. Hilliard

Signed.....

Student Embalmer

Licensed Embalmer No. *4291*

P. O. Address *4049 St Ferdinand*

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.