

FILED MAY 26 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16517

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4483

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		STREET ADDRESS (If rural, give location) 5 5670 Kingsbury Place., 205%	
3. NAME OF DECEASED (Type or Print) a. (First) Augusta b. (Middle) c. (Last) CAMPBELL			4. DATE OF DEATH (Month) (Day) (Year) May 20, 1955
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Sept 29 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Milliner	9. AGE (In years last birthday) 67
11. BIRTHPLACE (City and State or Foreign Country) St. Marys West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME A.M. Campbell		13b. MOTHER'S MAIDEN NAME Anna E. Spencer	14. NAME OF HUSBAND OR WIFE Nil
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Nil	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lorena Watkins, 119 E. 15th Tulsa, Oklahoma
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Interpillary glomerulosclerosis</u> ANTECEDENT CAUSES DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None performed</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 260X
22. I hereby certify that I attended the deceased from April 14, 1955, to May 20, 1955, that I last saw the deceased alive on May 20, 1955, and that death occurred at 10:10 p.m., from the causes and on the date stated above.			
23a. SIGNATURE <u>William Bondpaer</u>		(Degree or title) C	23b. ADDRESS 1515 Lafayette
23c. DATE SIGNED 5-21-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-21-55	24c. NAME OF CEMETERY OR CREMATORY Local
24d. LOCATION (City, town, or county) (State) Harrison, Arkansas			
DATE REC'D BY LOCAL REG. MAY 21 1955		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd

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

S.P. (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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *G. W. Wilkinson*.....

Licensed Embalmer No. *35*.....

P. O. Address *W. Laer*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.