

FILED APR 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9773

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 306 PRIMARY REG. DIST. CO. 604 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>ST. CHARLES</b> 0920		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. CHARLES</b>	
b. CITY OR TOWN <b>RURAL DARDENNE</b> (If outside corporate limits, write RURAL and give township)		c. CITY OR TOWN <b>O'FALLON</b> 0920 (If residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> )	
c. LENGTH OF STAY (in this place) <b>4 YRS</b>		d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BELLEAU CREEK RD. R.R.#2.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) <b>BELLEAU CREEK RD. R.R.#2</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>LORRTA</b> b. (Middle) <b>MARIE</b> c. (Last) <b>CAMPBELL</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 5 1957</b>		
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>	
8. DATE OF BIRTH <b>JAN. 20, 1943</b>		9. AGE (in years last birthday) <b>14</b> Months <b>2</b> Days <b>16</b>		10. HOURS <b>1</b> MIN. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>PORTAGE DES SIOUX, MO</b>	
12. CITIZENRY OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>WILLIAM R. CAMPBELL</b>		13b. MOTHER'S MAIDEN NAME <b>STELLA MARIE</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>INTESINAL Obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>PROGRESSIVE NUTRITIONAL &amp; DEFICIENCY</b>			
		DUE TO (c) <b>AND DETERIORATION</b>			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>CEREBRAL Palsy</b>			

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <b>2</b> 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? _____	

22. I hereby certify that I attended the deceased from July, 1956 to 4 Apr, 1957, that I last saw the deceased alive on 4 Apr, 1957, and that death occurred at 10:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>Kenn J. D. Hunter M.D.</b> (Degree or title)		23b. ADDRESS <b>O'Fallon, Mo</b>		23c. DATE SIGNED <b>6 Apr 57</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>APRIL 8, 1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S CATH. CEM</b>	
24d. LOCATION (City, town, or county) (State) <b>COTTEVILLE MO</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>E. L. Prinster, St. Charles Mo.</b> ADDRESS _____			
DATE REC'D BY LOCAL REG. <b>April 6-1957</b>		REGISTRAR'S SIGNATURE <b>E. A. Keitt</b>			

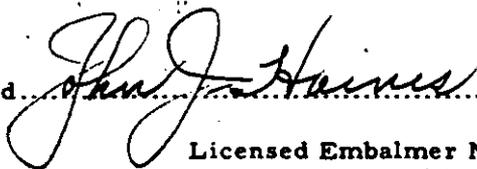
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....



Licensed Embalmer No. 4108

P. O. Address St. Louis Mo

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.