

FILED JUL 9 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH'57 022260  
STATE FILE NUMBER

Registration District No. 305 Primary Registration District No. 6047 Registrar's No. 16

Health,  
Welfare  
Public  
Service300  
1-56  
0920

Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Foristell</b>		c. CITY OR TOWN <b>Foristell</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS <b>0920 0</b> (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <b>Ed</b> Middle <b>A</b> Last <b>Campbell</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 20 1884</b>
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Man</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Tennessee</b>
13. FATHER'S NAME <b>John Campbell</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A</b>	
14. MOTHER'S MAIDEN NAME <b>Angeline Hollman</b>		17. INFORMANT <b>Ruth Campbell</b> Address <b>Foristell MO</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>49 5-22-8653</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, nose.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>1. Fract. of nose.</b> DUE TO (c) <b>191X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>10-17-55</b> to <b>6-10-57</b> and last saw <sup>him</sup> <del>her</del> alive on <b>6-25-57</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated			
22a. SIGNATURE <b>W. Cappel M.D.</b> (Deceased or title)		22b. ADDRESS <b>3284 ...</b>	
22c. DATE SIGNED <b>6-13-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/13/57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wright City Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Wright City MO</b>	
24. FUNERAL DIRECTOR <b>Nieburg Furn. &amp; Und. Co., Wright City, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>June 14 1957</b>	
26. REGISTRAR'S SIGNATURE <b>Walter Poff</b>			

(Licensed Embalmer's Statement on Reverse Side)

408  
157 0

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 *James J. Dickerson*.....

Licensed Embalmer No. *33*

P. O. Address *Wright City*

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.