

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012677

STATE FILE NUMBER

FILED APR 7 1958

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 877

300
1-57
4001

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Florissant</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Florissant</u> <u>4001</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2700 Holiday Hill Dr.</u> | | Length of stay in lb <u>1 Yr.</u> | d. STREET ADDRESS (If outside, give location) <u>2700 Holiday Hill Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES E. CAMPBELL</u> | | | 4. DATE OF DEATH Month Day Year <u>Mar. 27 1958</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 24, 1902</u> |
| 9. AGE (In years last birthday) <u>55</u> | | 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) <u>Ass't. Sup't. - Laclede Gas Co.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Charles E. Campbell</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Margaret Pease</u> | | 14. NAME OF HUSBAND OR WIFE <u>Joan Campbell</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>492-03-6688</u> | 17. INFORMANT Address <u>Joan Campbell 2700 Holiday Hill Dr.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno Carcinoma of Lung</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> |
| 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 Month, Day, Year a.m. p.m. | | | |
| 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 <u>12-26-57</u> to <u>3-27-58</u> and last saw him <u>alive</u> on <u>3-27-58</u> Death occurred at <u>5:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>J. H. Duran D.O. I</u> | | 22b. ADDRESS <u>330 St. Francois Florissant, Mo</u> | 22c. DATE SIGNED <u>3-27-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Mar. 31, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S. Kingshighway</u> | | 25. DATE RECD. BY LOCAL REG. <u>3-28-58</u> | 26. REGISTRAR'S SIGNATURE <u>Herbert B. Dombek</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in reporting. All diseases in Part I must be causally related.

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 *William C. White*

Licensed Embalmer No. *4391*

P. O. Address *2200 1/2 St. N. W.*

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.