

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024091
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1726

S. 300
1-57

A

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Valley Park</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Clayton 5, 44520</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>Moll's Nurs. Home</u>		Length of stay in lb <u>1 1/2 yr</u>	d. STREET ADDRESS (If outside, give location) <u>612 S. Hanley Rd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>KATHRYN</u> Middle <u>C.</u> Last <u>CAMPBELL</u>			4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11 1890</u>	9. AGE (In years) <u>67</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Joseph Conover</u>		13b. MOTHER'S MAIDEN NAME <u>Christina Paul</u>		14. NAME OF HUSBAND OR WIFE <u>Irving 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>158-10-7741</u>	17. INFORMANT Address <u>A.C. Blamey-Clayton 5, Mo.</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>Carcinoma of urinary bladder</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</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>Senile dementia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>181.0</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <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>Jan 1 1957</u> to <u>6/26/58</u> and last saw <u>her</u> alive on <u>6/24/58</u> Death occurred at <u>1051 Rm</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>D. H. Healy, M.D.</u>			22b. ADDRESS <u>Kirkwood 22, Mo</u>		22c. DATE SIGNED <u>6/27/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/28/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK Hill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Kirkwood, 22, Mo</u>	
24. FUNERAL DIRECTOR <u>Pfzinger Mort.</u>		ADDRESS <u>Kirkwood 22, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6/28/58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke, M.D.</u>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

No.

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 *Don E. Hoffmann*

Licensed Embalmer No. *24366*

P. O. Address *St Louis*

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.