

Cleared by Coroner-  
Mr. Taylor

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041373

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11391

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN East St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 24 Louie Children		Length of stay in lb 20 mins.	d. STREET ADDRESS (If outside, give location) 32 17a North 10th
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Campbell			4. DATE OF DEATH Month Day Year 11 17 58
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 0 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 59
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Joe Emanuel Campbell		13b. MOTHER'S MAIDEN NAME Marie Bender	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give year, date of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Luan Lehr, 500 S. Kingshighway
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal atelectasis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Prematurity DUE TO (c) 762.5			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 hr.
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 <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK 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 Death occurred at 11-17-58 2:25 a. to 11-17-58 and last saw her alive on 11-17-58			
22a. SIGNATURE (Degree or title) Wm J Klingberg M.D.		22b. ADDRESS 500 S. Kingshighway	22c. DATE SIGNED 11-17-58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11-29-58	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Rowland Aker 440 Manchester	ADDRESS	25. DATE RECD. BY LOCAL REG. NOV 26 58	26. REGISTRAR'S SIGNATURE Pearl Smith mo

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

**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.....

P. O. Address.....

**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.**