Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002799
STATE FILE NUMBER

FILED JAN 26 1959

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Overland — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Luke's Hospital — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 423 10401 Clarendon AVE — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Tishia Middle: Last: Campbell		4. DATE OF DEATH Month Day Year: January 1, 1959	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]	8. DATE OF BIRTH: Sept. 11, 1883
9. AGE (In years last birthday): 75	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: At Home	11. BIRTHPLACE (City and state or country): Moody, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME: Richard Wright	13b. MOTHER'S MAIDEN NAME: Susan Case	14. NAME OF HUSBAND OR WIFE: Oris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT Address: Susan Yaeger, 2333 Hood Ave.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Generalized arteriosclerosis with Hypertension — ?

DUE TO (c) 331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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 [ ] NOT WHILE AT WORK [ ]

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 Dec 19, 1958 to Jan. 1, 1959 and last saw her/him alive on Jan 1, 1959

Death occurred at 7 A.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Edwin P. Meiner M.D.	22b. ADDRESS: 6651 Enright Ave.	22c. DATE SIGNED: 1-2-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 1-1-59	23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Thayer, Mo.		
24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG.: JAN 3 '59	26. REGISTRAR'S SIGNATURE: J. Earl Smith MD (H.T)

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. 4108

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.