

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006962
STATE FILE NUMBER
2 1485

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
-57

72
6

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Phillips		d. STREET ADDRESS (If outside, give location) 4202 Delmar Ave.	
Length of stay in lb Life		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last MILDRED CAMPBELL			4. DATE OF DEATH Month Day Year Feb. 10, 1959		
--	--	--	---	--	--

5. SEX Female ³	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1929	9. AGE (In years last birthday) 29	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 --	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	---	---	--

13a. FATHER'S NAME Wilfred Campbell	13b. MOTHER'S MAIDEN NAME Ella Wilkins	14. NAME OF HUSBAND OR WIFE --
--	---	-----------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Wilfred Campbell	Address 3951 Evans Ave.
---	---------------------------------	-----------------------------------	----------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Bones of the Face and Suffocation.</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>934.046</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>suffered in area struck by tornado on February 10th</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury for PART I or PART II of item 18.) <i>injury</i>
--	--

20c. TIME OF INJURY Hour Month, Day, Year <i>2:10 a.m. 2 10 59</i>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>1922 Home</i>	20e. CITY, TOWN, OR LOCATION <i>St. Louis Mo</i>	COUNTY STATE
--	--	---	--------------

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.) <i>1922 Home</i>	20f. CITY, TOWN, OR LOCATION <i>St. Louis Mo</i>	COUNTY STATE
---	--	---	--------------

21. I attended the deceased from _____ to _____ and last saw her alive on _____ of the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Joseph M. Quinn</i>	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 2/11/59
--	----------------------------	-----------------------------

23a. BURIAL CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/14/59	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.
---	----------------------	--	--

24. FUNERAL DIRECTOR Charles J. Gates	ADDRESS 4107 Finney	25. DATE RECD. BY LOCAL REG. FEB 11 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
--	------------------------	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Rayton Swan*

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.