

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010787
STATE FILE NUMBER
2 2223
Registration No.

MAR 17 1959

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS MO</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5926 Southwest</u>		Length of stay in 1b <u>11 MONTHS</u>	d. STREET ADDRESS (If outside, give location) <u>5926 SOUTHWEST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LOUISA</u> Middle <u>-</u> Last <u>CAMPBELL</u>			4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1959</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>3-10-1885</u>	9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR: Months <u>-</u> Days <u>-</u> IF UNDER 24 HRS.: Hours <u>-</u> Min. <u>-</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>MULKKEY TOWN, ILL.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM SCHMIDT</u>		13b. MOTHER'S MAIDEN NAME <u>MENA HERMANN</u>		14. NAME OF HUSBAND OR WIFE <u>EMER 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>NONE</u>	17. INFORMANT Address <u>MRS. IRENE TONDINI 5926 Southwest</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>Myocarditis; Chronic Hypertension, chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>443x</u>	
	DUE TO (c)	
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 <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.)	
20c. TIME OF INJURY Hour <u>-</u> Month, Day, Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>		

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>1-3-59</u> to <u>3-2-59</u> and last saw ^{her} him alive on <u>3-2-59</u> Death occurred at <u>11:21 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Alfred M. Jangeneck M.D.</u>		22b. ADDRESS <u>6200 Hoffman Ave.</u>	22c. DATE SIGNED <u>3-2-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>3-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>De Quion, Ill</u>
24. FUNERAL DIRECTOR, ADDRESS <u>Ernest Michel 5930 Southwest</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 3 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>	

(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.

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1-57

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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 *V. E. Morris*

Licensed Embalmer No. *2360*

P. O. Address *St Louis, Mo*

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.