

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

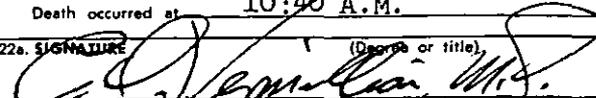
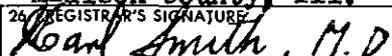
FILED VS DEC 11 1959

211126

59-041649

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI Length of stay in lb c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois. b. COUNTY Madison c. CITY OR TOWN Woodriver Township Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 214 Ladd, St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED First Middle Last (Type or print) LEO F. CAMPBELL			4. DATE OF DEATH Month Day Year 11 29 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/16/1895	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrument Electrician		10b. KIND OF BUSINESS OR INDUSTRY Shell Oil Co.		11. BIRTHPLACE (City and state or country) Fieldon, Illinois.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Levi Campbell		13b. MOTHER'S MAIDEN NAME Hettie Cope		14. NAME OF HUSBAND OR WIFE Ethel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. 343-10-9010		17. INFORMANT Address Ethel Campbell, Woodriver Township, Ill.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach with Metastases Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 151x					INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <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 October 24, 1959 to November 29, 1959 and last saw him alive on November 29, 1959 Death occurred at 10:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Name or title) 			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 11/30/59
23a. BURIAL, CREMATION REMOVAL (Specify) Removal		23b. DATE 12-2-59	23c. NAME OF CEMETERY OR CREMATORY Valhalla Memorial Park Cem.		23d. LOCATION (City, town, or county) (State) Madison County, Ill.
24. FUNERAL DIRECTOR ADDRESS Smith Funeral Homes, Alton, Illinois.		25. DATE RECD. BY LOCAL REG. DEC 1 1959		26. REGISTRAR'S SIGNATURE 	

MAILED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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Instrument Electrode

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Hettie Gore

Label

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113-10-9010

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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 _____

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.

11-3-31

Illinois

Illinois State Board of Health

Not Embalmed by [Signature]