

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017559

FILED VS APR 22 1960

317

548

1302

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webster Groves</b>		Length of stay in 1b <b>5 mos.</b>	c. CITY OR TOWN <b>University City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Glenwood Sanitarium</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6833 Kingsbury Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>MRS. OCTAVIA AGNES CAMPBELL</b>			4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/31/1881</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>James White</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Fox</b>		14. NAME OF HUSBAND OR WIFE <b>Eugene O. Campbell</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (or unknown)) (If yes, give war and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>94-307-793</b>		17. INFORMANT <b>Mrs. Grace Yost 9023 Eager (17)</b> Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Arteriosclerotic heart disease</b>			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Vascular Accident</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ 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 <b>11/5/59</b> to <b>4/2/60</b> and last saw her <sup>her</sup> <sub>mm</sub> alive on <b>4/2/60</b> Death occurred at <b>4:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree and Title) <i>[Signature]</i>		22b. ADDRESS <b>150 N. Meramec, Clayton 5, Mo.</b>		22c. DATE SIGNED <b>4/4/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4/5/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blvd.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>4-5-60</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Thos. T. Flynn  
150 No. Meramec

PA6-3202

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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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J. J. Mulla  
Licensed Embalmer No. 976

P. O. Address 6130

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.

Embalmer