

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS AUG 17 1960

=60-031990

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7720 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO</u>		Length of stay in 1b <u>3 1/2 Yrs.</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>5812 Prescott</u>
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First Middle Last <u>CAMPBELL</u>		4. DATE OF DEATH <u>AUG. 2, 1960</u> Month Day Year	

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/81</u>	9. AGE (last birthday) <u>78</u>	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) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Iron Co., Mo.</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>James Campbell</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Reed</u>	14. NAME OF HUSBAND OR WIFE <u>Martha Campbell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>Unk.</u>	17. INFORMANT <u>Martha Campbell, 5812 Prescott, St. L</u> 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) <u>SEVERE OLIGURIA</u> DUE TO (b) <u>URETERO-VESICAL JUNCTION OBSTRUCTION</u> DUE TO (c) <u>CARCINOMA OF URINARY BLADDER GRADE IV</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>181.0</u>		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 <u>7/29/60</u>	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 <u>8/2/60</u>	COUNTY	STATE
--	--	--	---	--------	-------

21. I attended the deceased from 7/29/60 to 8/2/60 and last saw <sup>her</sup>/<sub>him</sub> alive on 8/2/60  
Death occurred at 5:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>George H. McLaughlin M.D.</u> (Degree or title)	22b. ADDRESS <u>1515 LAFAYETTE AVE</u>	22c. DATE SIGNED <u>8/3/60</u>
--	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8/5/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Trinity</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
---	----------------------------	--	--

24. FUNERAL DIRECTOR <u>McLaughlin, 2301 Lafayette (4)</u> ADDRESS	25. DATE RECEIVED BY LOCAL HEALTH DEPARTMENT <u>AUG. 5 1960</u>	26. REGISTRARS SIGNATURE <u>Geoff Smith, M.D.</u>
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

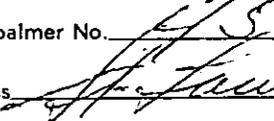
**STATEMENT BY LICENSED EMBALMER**

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 \_\_\_\_\_  


Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_  


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