

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 Days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Alice Camden SAS

3. (b) If veteran, name war _____ **3. (c) Social Security No.** None

4. Sex Female **5. Color or race** White **6. (a) Single, widowed, married, divorced.** Single

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased September 27, 1920.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>18</u>	<u>11</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace Randall County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business _____

MOTHER

FATHER

12. Name Shelton Camden
18. Birthplace Iron County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Lottie Holt
15. Birthplace Randall County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Shelton Camden
(b) Address West Fork Missouri

17. (a) Burial _____ **(b) Date thereof** 9/19/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Fork Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.,

19. (a) SEP 20 1939 **(b)** J. B. [Signature]

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3128 Henfield Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 17,
 year 1939 hour 9:30 minute A. M.

21. I hereby certify that I attended the deceased from September 15,
1939 to September 17, 1939
 that I last saw her alive on September 17, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid fever **Duration** four

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy as above

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ **(Specify type of place)**
 _____ **(Means of injury)**

23. Signature [Signature] **(M. D. or other)** _____
Address 1515 Lafayette, **Date signed** 9/18/39

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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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Guy W. Welkin*

Licensed Embalmer No..... *3575*

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 this body is not embalmed, above space should be left blank.