DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34324

Registration District No. 791 ~~1008~~

Primary Registration District No.

Registrar's No. 8862

1. PLACE OF DEATH:

(a) County REC'D NOV 13 1939

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No. 4128a Finney
(If rural, give location)

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

3. (a) PRINT FULL NAME Magdaline Campbell 514

3. (b) If veteran, name war ----

3. (c) Social Security No. ----

4. Sex F

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Blonze Campbell

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan. 29, 1904
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
35	8	14	hr. min.

9. Birthplace Nashville (City, town, or county) Tenn. (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Samuel Rose
13. Birthplace Frankfort, (City, town, or county) Ky. (State or foreign country)

MOTHER
14. Maiden name Lula Walker
15. Birthplace Nashville, (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant's own signature Wm W. Rose
(b) Address 4311 St. Louis Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/39 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas J. Gates
(b) Address 4107 Finney Ave.

19. (a) OCT 18 1939 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10- day 13
year 1939 hour 6:00 minute A M.

21. I hereby certify that I attended the deceased from 9-13-, 1939, to 10-13, 1939
that I last saw her alive on 10-13-, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
PULMONARY TUBERCULOSIS	About 2 yrs.
Due to ----	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature M. W. Allen (M. D. or other)
Address 2601 N. Whittier Date signed 10-13-39

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39 I X19811

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 James A. Johnson, Registered Apprentice No. ____, working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave.

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.