

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.

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1445a Madison St.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
(Specify whether)
 In this community 45 years
years, months or days

3. (a) PRINT FULL NAME Belle Campbell
 8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife John Campbell 6. (c) Age of husband or wife if alive 49 years
 7. Birth date of deceased April 19 1894
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>9</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation Housewife 9

11. Industry or business _____ 9

MOTHER FATHER { 12. Name J.M. Gross 7

13. Birthplace unk (State or foreign country) 7

14. Maiden name unk (State or foreign country)

15. Birthplace unk (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Campbell
 (b) Address 1445a Madison St.

17. (a) Burial (b) Date thereof Feb. 8 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director Concordia Funeral Home
 (b) Address 1936 St. Louis Ave

19. (a) FEB 7 1940 (b) J. Blodgett
(Date received local register) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis 26
(If outside city or town limits, write "RURAL")
 (d) Street No. 1445 Madison St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb. day 6
 year 1940 hour 4:45 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Oedema of Brain; Cor Bovis
Chronic Myocarditis;

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

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____

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)
 (e) Means of injury _____

28. Signature John Campbell (M. D. or other) _____
 Address _____ Date _____

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.....

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