No. 2
1/47
6-17-39

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JAN 9 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 42904
Registrar's No. 11949

1. PLACE OF DEATH:
(a) County: St. Louis Mo
(b) City or town: (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillip Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) / In this community 9 year,s

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 000
(c) City or town: St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No.: 4319 St. Louis Ave Apt 2I (If rural, give location) 9
10
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME: Davis Camphor
3. (b) If veteran, name war: no
3. (c) Social Security No.: No
4. Sex: Male
5. Color or race: Col
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Oct (Month) 29 (Day) 1858 (Year)

8. AGE:

Years	Months	Days	If less than one day
89	2		hr. min.

9. Birthplace: (City, town, or county) Miss (State or foreign country)
10. Usual occupation: Labor
11. Industry or business:
FATHER
12. Name: Dave Camphor
13. Birthplace: Port Gibson Miss (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Fannie Camphor
15. Birthplace: Port Gibson Miss (City, town, or county) (State or foreign country)
16. (a) Informant: Mr Frank Camphor
(b) Address: 4319 St. Louis Ave Apt 2I
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12/31/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Port Gibson Miss
18. (a) Signature of funeral director: Herman J Smith
(b) Address: 4247/w Labadie Ave
19. (a) DEC 30 1947 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 year 1947 hour 12 minute 10 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.

	Duration
Immediate cause of death: Coronary Thrombosis	
Due to:	
Due to: 94	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN
Underline the cause of 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: 3
23. Signature: (M. D. or other)
Address: Date signed 12/30/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Lawrence E. Hodson

Licensed Embalmer No. 4143

P. O. Address St Louis Mo

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, fact should be so stated above.

No. 2B
M—3-45
I X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 11949

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Davis Campbell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if living —

7. Birth date of deceased Oct 29 (Month) (Day) (Year)

8. AGE: Years 89 Months Days If less than one day hr. min.

9. Birthplace Fort Gibson Miss (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature) JAN 14 1949

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year hour minute 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 — Duration

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. D. or other)
Address Date signed

SUPPLEMENTARY

42904

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