

U.S. No. 300
FORM-10-47
Rev. 5-17-39
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 15 1948

Registration District No. 277

Primary Registration District No. 2002

Registrar's No. 1204

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Christian Old Peoples Home 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 years 3 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town University City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 6600 Washington Avenue 5
(If rural, give location) 0

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

If yes, name country _____

3: (a) PRINT FULL NAME ANNA CAMPBELL

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10, 1948
year 6 hour 30 minute A M.

21. I hereby certify that I attended the deceased from Jan 1-48
1948, to May 10, 1948
that I last saw her alive on May 7 1948
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

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

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

7. Birth date of deceased January 6, 1861
(Month) (Day) (Year)

Immediate cause of death Myocardial degeneration Duration 4 m

Due to Senility

Due to 930

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

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

87	4	4	hr. min.
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9. Birthplace West Salem Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

12. Name Ira C. Shelby

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

14. Maiden name Ellen Greathouse

15. Birthplace Unknown 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mary E. Craig

(b) Address 6600 Washington Avenue

17. (a) Burial (b) Date thereof May 11, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VALHALLA CEMETERY

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address 1167 Hamilton Avenue

19. (a) 5-7-48 (b) Beneby Shelby
(Date received local registrar) (Registrar's signature)

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 _____

23. Signature J. R. Myers (M. D. or other) _____

Address 607 N. Grand Bl Date signed 5-10-48

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

Fred G. Brammer

Licensed Embalmer No. *4200*

P. O. Address *St. Louis*

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.