

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22059

BIRTH NO.		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076		Registrar's No. 1202	
1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>NORMANDY</u>		c. LENGTH OF STAY (in this place) <u>1</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>NORMANDY</u>		96 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5313 WUCAS HUNT RD</u>				d. STREET ADDRESS (If rural, give location) <u>5-313 WUCAS & HUNT RD</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>GEORGE</u>		b. (Middle) <u>WALTER</u>		c. (Last) <u>CAMPBELL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5 16 49</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>DEC 16, 1922</u>	
9. AGE (In years last birthday) <u>26</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHIROPRACTOR</u>		11. BIRTHPLACE (State or foreign country) <u>IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>WILLIAM M. CAMPBELL</u>		13b. MOTHER'S MAIDEN NAME <u>LORENA M. COURRIER</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR II</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Dr. Wm. M. Campbell</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sarcoma of bone - left thigh</u>				INTERVAL BETWEEN ONSET AND DEATH <u>about 18 mos</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>196X</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>3/29/48</u>		19b. MAJOR FINDINGS OF OPERATION <u>Sarcoma left thigh - amputation</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 29, 1948</u> , to <u>May 16, 1949</u> ; that I last saw the deceased alive on <u>May 16, 1949</u> , and that death occurred at <u>1:25 AM</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Sam F. Dean M.D.</u>				23b. ADDRESS <u>3720 Washington St. St. Louis</u>		23c. DATE SIGNED <u>5/16/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>5/18/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
DATE REC'D BY LOCAL REG. <u>5-17-49</u>		REGISTRAR'S SIGNATURE <u>Howard V. Livingston</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>William J. Muller 5165 DELMAR BL.</u>			

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

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 _____

..... Student Embalmer No.

working under my personal supervision.

Signed A. G. Farris

Signed
Student Embalmer

Licensed Embalmer No. 3384

P. O. Address A. G. Farris

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.