

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28444

State File No.

BIRTH NO. _____ REG. DIST. NO. 517 PRIMARY REG. DIST. NO. 547 Registrar's No. 1906

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Richmond Heights</u>	c. LENGTH OF STAY (in this place) <u>7 days</u>	c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>535 Clara Avenue/</u> <u>2257</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Edmond</u>	b. (Middle) <u>Arthure</u>	c. (Last) <u>Campagna</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 16, 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 16 1878</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shirt Cutter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Elder Mfg. Co.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Montreal Canada</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Joseph Campagna</u>	13b. MOTHER'S MAIDEN NAME <u>Unavailable</u>	14. NAME OF HUSBAND OR WIFE <u>Mamie Campagna</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mamie Campagna</u>	ADDRESS <u>535 Clara Avenue</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Vascular Accident</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchial Asthma</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>331 x</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 8/9, 1955 to 8/16, 1955 that I last saw the deceased alive on 8/16, 1955, and that death occurred at 9:55A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Edward S. Kusella</u>	23b. ADDRESS <u>3720 Washington</u>	23c. DATE SIGNED <u>8/16/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>8-17-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	24d. LOCATION (City, town, or county) (State) <u>Newton, Illinois</u>
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DATE REC'D BY LOCAL REG. <u>9/16/55</u>	REGISTRAR'S SIGNATURE <u>Hebert K. Romberg, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>	ADDRESS <u>4700 Washington Blvd</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Registration on Reverse Side)

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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..

Student..... Signature of Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 37490

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.