

FILED JUN 7 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17662

State File No. 4996
Registrar's No. 1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 4996		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		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 BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) 14 5603 Neosho St.				
3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) Alexander c. (Last) Campbell			4. DATE OF DEATH (Month) (Day) (Year) May 23, 1956					
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 23, 1890		
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 28 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor			10b. KIND OF BUSINESS OR INDUSTRY S. W. Bell Tel. Co.		11. BIRTHPLACE (City and State or Foreign Country) Springfield, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John Campbell			13b. MOTHER'S MAIDEN NAME Wilmina		14. NAME OF HUSBAND OR WIFE Flora B. Campbell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Flora B. Campbell 5603 Neosho St.			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis (primary site - rectum) ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 15 mos.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 157X				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 May 8, 1956 , to May 23, 1956 , that I last saw the deceased alive on May 23, 1956 and that death occurred at 10:10 A.M. , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) C. C. McMillin, M.D. M. D.				23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 5/23/56		
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE May 25, 1956		24c. NAME OF CEMETERY OR CREMATORY Hazelwood Cemetery		24d. LOCATION (City, town, or county) (State) Springfield, Mo.		
DATE REC'D BY LOCAL REG. MAY 24 1956		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hoffmeister Colonial Mortuary 6464 Chippewa St., St. Louis, Mo.				

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..

Student.....
Signature of Student Embalmer

Signed.....
James C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 7814 S. B.

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.