

pt. Health,
c., & Welfare
S. Public
alth Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41826

FILED NOV 21 1957

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9384

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Flat River		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 31 301 East Main St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Robert Lee Campbell Jr.			4. DATE OF DEATH Month Day Year Oct. 6, 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1910	9. AGE (In years last birthday) 47 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Underground Machinist		10b. KIND OF BUSINESS OR INDUSTRY St. Joseph Lead	11. BIRTHPLACE (City and state or country) Bonne Terre, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Robert Lee Campbell Sr.		13b. MOTHER'S MAIDEN NAME Dora Elizabeth Aberle		14. NAME OF HUSBAND OR WIFE Unavailable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. 498-03-3339	17. INFORMANT Address Mr. Ralph Campbell, 101 E. Main Flat River Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Skull;</i> DUE TO (b) <i>Subarachnoid Hemorrhage</i> DUE TO (c) <i>Pulmonary Oedema;</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Suffered when deceased was</i>					INTERVAL BETWEEN ONSET AND DEATH <i>Mo. 2 E 9:10 4</i>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature, extent in PART I or PART II of item 18.) <i>injured in a head</i>			
20c. TIME OF INJURY Hour Month, Day, Year <i>7:30 p.m. 10 25 57</i>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>31 Mine</i>			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <i>near Bonne Terre Mo</i>		STATE <i>Mo</i>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <i>1240 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>James M Kelly Doctor</i>		22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>10-8-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>10-7-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bonne Terre Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Bonne Terre, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Albert H. Hoppe 4700 Washington.</i>			25. DATE RECD. BY LOCAL REG. <i>OCT 8 57</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith Mo</i> <i>m JB</i>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. *3749*

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