MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

373

426

1. PLACE OF DEATH
County Buchanan — Registration District No. 85
Township — Primary Registration District No. 1001
City St Joseph (No. ..... St. ..... Ward)

File No. ..... Registered No. 134

2. FULL NAME Lydia Campbell
(a) Residence. No. State Hosp #2 St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1851
7. AGE Years 78 Months unk Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) Key
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) "
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) "
(STATE OR COUNTRY)

14. INFORMANT records, Hospital
(Address) St. Joseph Mo.
15. FILED JAN 31 1929 John G. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 30 1929
17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1929, to Jan 30, 1929 that I last saw her alive on Jan 30, 1929 and that death occurred, on the date stated above, at 5 P. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis,
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? unknown
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical.
(Signed) E. S. Birends, M. D
1/30, 1929 (Address) State Hospital #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kansas City Mo — DATE OF BURIAL 2/1 1929
20. UNDERTAKER Fleeman Funeral Home — ADDRESS 1208 Francis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE FORMS, WITH UNFADING INKS, THIS IS A PERMANENT RECORD

FEB 31 1929

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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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File No. ..... Registered No. ..... St. ..... (No.) ..... Ward)

Registration District No. ..... Primary Registration District No. .....

1. PLACE OF DEATH

(City) ..... (No.) ..... St. ..... Ward)

Township ..... Village ..... Hospital .....

2. FULL NAME .....

3a. If married, widowed, or divorced — HUSBAND OF WIFE (OR) WIFE OF HUSBAND

3b. Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... Street ..... No. ..... (Usual place of abode) ..... (If nonresident give city or town and state) ..... How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... dys.

PERSONAL AND STATISTICAL PARTICULARS

4. SEX	5. COLOR OR RACE	6. DATE OF BIRTH (Month, day and year)			7. AGE	
		Months	Days	Years	Years	If LESS than 1 day, ... hrs. ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (City or town) .....

(State or country) .....

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (City or town) .....

(State or country) .....

PARENTS

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (City or town) ..... (State or country) .....

14. INFORMANT .....

(Address) .....

15. Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month, day and year) 19

I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 ..... and that death occurred, on the date stated above, at ..... m.

The cause of death* was as follows:

17. .....

.....

.....

.....

.....

18. Where was disease contracted ..... (diseases) ..... yrs. ..... mos. ..... dys.

If not at place of death, ...

Did operation precede death? ..... Date ..... 20.

Was there an autopsy? .....

What test confirmed diagnosis? .....

Was injury the result of accident, suicide or homicide? .....

20. UNDERTAKER .....

(Signed) ..... 19 .....

(Address) .....

21. PLACE OF BURIAL, CREMATION, OR REMOVAL .....

22. DATE OF BURIAL .....

23. ADDRESS .....

I, the undersigned, hereby certify that I attended the deceased from the date and to the date stated above, and to the best of my knowledge death occurred on the date stated above, at the hour stated, from the causes stated.

Signed ..... M.D.

Place an "X" in the square if autopsy was held.

(1) Date of death confirmed by autopsy ☐

(2) Autopsy showed no other causes of death than those given ☐

(3) Autopsy showed other causes of death than those given ☐

Place an "X" in the square if coroner's inquest was held ☐

Place an "X" in the square if disease was reported to health officer ☐

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.