

S. No. 2
-11-10-39
v. 5-17-39
-I X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31011
Registrar's No. 3574

Registration District No. 399 Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Law
(c) Name of hospital or institution: H. C. Sun Hosp
(d) Length of stay: In hospital or institution 4 days
In this community Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jackson
(c) City or town Kansas City
(d) Street No. 548 1/2 Main
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William Campbell
(b) If veteran, name war no
(c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 6 day 21 year 1940
21. I hereby certify that Coroner the deceased from 3:00 a.m.
that deceased alive on 19 and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex M 5. Color of race W 6. (a) Single, widowed, married, divorced No Record
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased No Record
8. AGE: Years 58 Months about Days _____ If less than one day _____ hr. _____ min.

Duration _____
Due to Fracture of the skull
Other conditions (Include pregnancy within 3 months of death) 194 B
Major findings: Of operations 40
Of autopsy _____

9. Birthplace _____
10. Usual occupation none
11. Industry or business _____
12. Name Unknown
13. Birthplace _____
14. Maiden name Unknown
15. Birthplace _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Rec'd Clerk
(b) Address H. C. Sun Hosp
(c) Place: burial or cremation buried
17. (a) Date thereof Sept 5-40
(b) Signature of informant Wm. M. Crowe
(c) Address H. C. Sun Hosp
18. (a) Sept. 13, 1940
(b) M. M. Crowe

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 6-17-40
(c) Where did injury occur? K.C. MO
(d) Did injury occur in or about home, on farm, in industrial place, in public place? work
While at work? _____
23. Signature William M. Crowe (M. D. or other) _____
Address K.C. MO Date signed _____

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.