

No. 2
9-4-41
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13149

FILED MAY 10 1945

Registration District No. 3013 Primary Registration District No. 3013 Registrar's No. 24

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town North Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 18 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay ²⁴

(c) City or town North Kansas City Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 2009 Fayette
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Elizabeth Campbell

(b) If veteran, name war _____

(c) Social Security No. 496-03-8268

4. Sex F 5. Color or race Wht 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James H. Campbell 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 14-1894
(Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days 27 hr. _____ min. _____

9. Birthplace Lancaster Ky
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business H. W.

MOTHER FATHER

12. Name James W. Campbell

13. Birthplace Ky
(City, town, or county) (State or foreign country)

14. Maiden name Mary Stone

15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant James H. Campbell

(b) Address North Kansas City Mo

17. (a) Liberty (b) Date thereof 3-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Mo

18. (a) Signature of funeral director Walter Samuel

(b) Address North Kansas City Mo

19. (a) May 7-1945 (b) Ruth W. Henry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11 year 1945 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from 8-17-43 to death, 1945
that I last saw her alive on 3-10, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Carcinomatosis ^{Duration 3 yrs}

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? PH Warehouse (Specify type of place) _____
(Means of injury) _____

23. Signature Ruth W. Henry (M. D. or other) _____

Address North KC, Mo Date signed 3/10/45

1021

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 5/9/45

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 John S. Morten
Licensed Embalmer No. 4349

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, fact should be so stated above.

Registration District No. 72

Primary Registration District No. 3013

1. PLACE OF DEATH:
(a) County Clay
(b) City or town North Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Sarah E. Campbell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 14 1882
(Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days _____ (Less than one day) _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month MAY 11
year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. (Immediate cause of death) _____

This patient went through Wm. Dolher Clinic + Pharmacy; was not found
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature J. Allen (M. D. or other) _____
Address _____ Date signed _____
(Specify type of place) _____ (e) Means of injury _____

SUPPLEMENTARY INFORMATION REQUESTED

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

MOTHER FATHER

13149