

S. No. 300  
M-10-47  
v. 5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

29698  
State File No. \_\_\_\_\_  
Registrar's No. 3728

FILED SEP 25 1948  
Registration District No. \_\_\_\_\_

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 Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 34 hrs.  
(Specify whether  
In this community see above  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3901 Michigan  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Linda Sue Campbell  
(b) If veteran, name war no  
(c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 1  
year 1948 hour 2 minute 10 P. M.  
21. I hereby certify that I attended the deceased from  
June 30 1948 to July 1 1948  
that I last saw her alive on July 1 1948  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
(b) Name of husband or wife \_\_\_\_\_ (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased: June 30, 1948  
(Month) (Day) (Year)

Immediate cause of death Prematurity  
Due to \_\_\_\_\_  
Duration \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1  
If less than one day 10 hr. \_\_\_\_\_ min.

Due to 1  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy None  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Kansas City General Hospital No.  
(City, town, or county) (State or foreign country)  
10. Usual occupation infant

11. Industry or business \_\_\_\_\_  
12. Name John Edward Campbell  
13. Birthplace Richmond, Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Clara Ellen Corkendale  
15. Birthplace Lexington, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk  
(b) Address K. C. General Hospital No. 1  
17. (a) Burial (b) Date thereof 9-11-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation buried  
18. (a) Signature of funeral director Wm. A. [unclear]  
(b) Address City [unclear]  
19. (a) 9-13-48 (b) Steraldine [unclear]  
(Date received local registrar) (Registrar's signature)

23. Signature Wm. W. Hart (M. D. or other) MD  
Address Med. Dir. Gen'l Hosp. Date signed 7-2-48

**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.....

*Not Embalmed*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Wm. A. [Signature]*

Licensed Embalmer No. ....

*3089*

P. O. Address.....

*R. C. [Signature]*

**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.**