

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032573

STATE FILE NUMBER

63983-58

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4171

HEP SEP 24 1958

1. PLACE OF DEATH  
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Mo. b. COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Inside Limits Yes  No

c. CITY OR TOWN Kansas City, Mo. Inside Limits Yes  No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital Length of stay in lb 36 hrs.

d. STREET ADDRESS (If outside, give location) 10108 White Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First Middle Last David Earl Campbell

4. DATE OF DEATH Month Day Year 9 2 58

5. SEX Male 6. COLOR OR RACE White 7. MARRIED  NEVER MARRIED  WIDOWED  DIVORCED  8. DATE OF BIRTH 8-31-58 9. AGE (In years last birthday) 2 10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) infant 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) Kansas City, Mo. 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Lloyd Victor Campbell 13b. MOTHER'S MAIDEN NAME Carolyn Ann Ramsey 14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) No 16. SOCIAL SECURITY NO. none 17. INFORMANT Lloyd Victor Campbell Address 10108 White KC 34, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH CAUSED BY:  
IMMEDIATE CAUSE (a) *Cerebral malaria*  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) *atelectasis of lung*  
DUE TO (c)   
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) *6 1/2 mo pneumonia ruptured membrane*  
INTERVAL BETWEEN ONSET AND DEATH *20-20 months*  
*1 day*  
*7625*

19. WAS AUTOPSY PERFORMED? YES  NO  2

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT  NOT WHILE AT WORK

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from *8-31-58* to *9-2-58* and last saw her alive on *9-1-58*  
Death occurred at *4:42 AM* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *John T. Skinner MD* 22b. ADDRESS *2102 Greenwood St. EMO* 22c. DATE SIGNED *9-2-58*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Removal* 23b. DATE *9-2-58* 23c. NAME OF CEMETERY OR CREMATORY *Piedmont* 23d. LOCATION (City, town, or county) (State) *Piedmont, Kansas*

24. FUNERAL DIRECTOR *Mable Thurman Severy* ADDRESS *Rt. 1* 25. DATE RECD. BY LOCAL REG. *9-2-58* 26. REGISTRAR'S SIGNATURE *Irene Marshall*

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

John T. Skinner



**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 .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.**

**If this body is not embalmed, fact should be so stated above.**