

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

Do not use this space.

11992

File No. \_\_\_\_\_  
 Registered No. 1789  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Kaw Primary Registration District No. 1007  
 City Kansas City (No. St. Mary's Hospital)

**2. FULL NAME** Minnie E. Campbell

(a) Residence, No. 2400 East 10th St. St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widowed</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Geo. A. Campbell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 29, 1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>54</u>	<u>1</u>	<u>10</u>	

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work at home  
 (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) Illinois

10. NAME OF FATHER Wm. Killough

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Tenn

12. MAIDEN NAME OF MOTHER Eliza Catlin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Illinois

14. INFORMANT J. R. Turner  
 (Address) 209 E 10th St

15. FILED 5/1 27 M. M. Crowe  
 19\_\_\_\_ REGISTRAR Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28<sup>th</sup> 1927

17. I HEREBY CERTIFY, That I attended deceased from April 28<sup>th</sup> 1927 to April 28<sup>th</sup> 1927, and that I last saw him alive on April 28<sup>th</sup> 1927, and that death occurred, on the date stated above, at 9:00 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Double Pneumonia  
108  
120 B (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 da.

CONTRIBUTORY Acute Colitis  
 (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 23 da.

18. WHEN CASE FIRST CONTACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH: Her home 2400 E. 10th

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Laboratory

(Signed) Wm. M. Crowe M. D.  
4-30, 1927 (Address) 814 Argyle Bldg

\*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 St. Mary's Cem. DATE OF BURIAL 5-2 1927

20. UNDERTAKER Stine + McClure ADDRESS 924 Oak

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 399 File No. ....  
 Town or City St. Louis City (No. ....) Primary Registration District No. 1002 Registered No. 1789  
 City (No. ....) St. .... Ward)

**2. FULL NAME** Minnie B Campbell

(a) Residence No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 19 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
54 | 1 | 9 | | |

**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)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 571 19 27 M. M. Cronin REGISTRAR  
West

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 28 1927

17. I HEREBY CERTIFY that I attended deceased from ..... 19....., 19.....  
 (that I last saw him ..... alive ..... 19....., and that death occurred, on the date stated above) .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) ..... yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRACTED (duration) ..... yrs. .... mos. .... da.

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D.

, 19 (Address)

\*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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-11992