

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

Do not use this space.

6594

1. PLACE OF DEATH

County Jackson
Towship New
City Kansas City

Registration District No. 399
Primary Registration District No. 100
(No. 5844 East 10th St)

File No. _____
Registered No. 759
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 5844 E 10th St., 12th 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Campbell deceased Nov 25-28

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 28-1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
59 | 1 | 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home
(b) General nature of industry, business, or establishment in which employed (or employer). mother
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Merioneth Wales
(STATE OR COUNTRY) north

10. NAME OF FATHER Evan Ellis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) North Wales
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Shirn Owen

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

14. INFORMANT Wm E Campbell
(Address) 719 Whelshing

15. FILED 15-27 M M Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Thurs
Febr 14 1929

17. I HEREBY CERTIFY That I attended deceased from Dec 4, 1928 to Feb 14, 1929, that I last saw h. at alive on Feb 14, 1929, and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Bladder Neck

4415 (duration) 1 yrs. mos. da.
CONTRIBUTORY Metastatic Carcinoma of Lung
(SECONDARY) A to E (duration) 3 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____

20. WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS?
Autopsy for Lung

(Signed) E. W. W. Williams M. D.
2/13/29 19 (Address) 1824 East 10th St

*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 Mt Moriah DATE OF BURIAL 2-18 1929

20. UNDERTAKER Eylan Funeral Home 1800 Linwood 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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