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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33993
3933

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days (Specify whether years, months or days)

In this community 71 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048

(c) City or town Kansas City 3 8
(If outside city or town limits, write "RURAL")

(d) Street No. Lyndhurst Hotel-300 East 40th
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ---

3. (a) PRINT FULL NAME Mrs. May Hinkle Campbell

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mr. Fred Campbell

6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased May (Month) 27 (Day) 1867 (Year)

8. AGE: Years 74 Months 4 Days 24 If less than one day ___ hr. ___ min.

9. Birthplace Bath (City, town, or county) New York (State or foreign country)

10. Usual occupation At Home

11. Industry or business ---

FATHER
12. Name William Neally
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Matilda Rowena
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Leon C Hinkle
(b) Address 3931 Oak St.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1941 (Month) (Day) (Year)
(c) Place: Burial or cremation D. W. Newcomer's Sons

18. (a) Signature of funeral director D. W. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20th year 1941 hour 5 minute 05 P.M.

21. I hereby certify that I attended the deceased from Oct. 16, 1941, 19..., to Oct 20, 19..., that I last saw h. on alive on Oct 20, 19..., and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchio pneumonia	5 days
Due to Chronic bronchitis with an acute exacerbation	
Due to Senility	
Other conditions — (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

107

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Esther Wilhelm (M. D. or other) M.D.
Address 4050 Broadway Date signed 10-21-41

(Licensed Embalmer's Statement on Reverse Side)

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 C. Hervey Gunsenhe

Licensed Embalmer No. 4070

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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

S. No. 2B
M—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 53993

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 3933

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: (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 years, months or days) In this community:

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:

3. (a) PRINT FULL NAME: Mrs. May H. 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: W
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: May 27, 1867 (Month) (Day) (Year)

8. AGE: Years 74 | Months 4 | Days 28 | If less than one day: hrs. min.

9. Birthplace: (City, town, or county) (State or foreign country)
10. Usual occupation:
11. Industry or business:
FATHER
12. Name:
13. Birthplace: (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name:
15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant:
(b) Address:
17. (a) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)
(c) Place: burial or cremation:
18. (a) Signature of funeral director:
(b) Address:
19. (a) Jan. 29, 1942 (Date received local registrar) (b) R. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct. day: 26 year: 1941 hour: minute: M.
21. I hereby certify that I attended the deceased from: 19 to 19; that I last saw him alive on: 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death:	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy:

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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: (M. D. or other)
Address: Date signed:

SUPPLEMENTARY

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