

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

341

FILED JAN 30 1943

Registration District No. 149

Primary Registration District No. 1002

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:  
Tate Convalescent Home 3231 Prospect 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 yr.  
(Specify whether  
In this community 20 yrs.  
years, months or days)

3. (a) PRINT FULL NAME Lenora Ungeheuer 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 married  
6. (b) Name of husband or wife Patrick Watson Campbell 6. (c) Age of husband or wife if alive 74 years  
7. Birth date of deceased Oct. 21, 1869  
(Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Linn County Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Jacob Ungeheuer  
13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Walker  
15. Birthplace North Carolina  
(City, town, or county) (State or foreign country)

16. (a) Informant patrick Watson Campbell  
(b) Address 2406 Indiana

17. (a) removal (b) Date thereof 1- 24- 1943  
(Specify type of place) (Month) (Day) (Year)

(c) Place: burial or cremation College mound, Mo.  
D. W. Newcomer's Sons

18. (a) Signature of funeral director  
(b) Address 1401 Brush Creek Blvd.

19. (a) 1-23-43 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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. 2406 Indiana  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 22  
year 1943 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan. 1  
1943 to Jan. 22 1943  
that I last saw her alive on Jan. 22 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
Chronic myocarditis  
Cerebral hemorrhage  
Due to Hypertension

Duration  
1 day  
5 yrs.

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no

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?

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature M. B. Caselbert M.D. (M. D. or other)  
Address 715 Angyle Bldg. Kansas City Date 1-26-43

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

---

---

**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.....

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