

FILED OCT 24 1944

Registration District No. 149

Primary Registration District No. 1602

Registrar's No. 4116

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

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:  
651- WEST-70TH STREET  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 2 1/2 YEARS  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL")

(d) Street No. 651- WEST-70TH STREET  
(If rural, give location)

(e) Citizen of foreign country? YES (Yes or No)  
If yes, name country ITALY

3. (a) PRINT FULL NAME MR. BENJAMIN F CAMPANA

(b) If veteran, name war NO

(c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 12<sup>TH</sup>  
year 1944 hour 3 minute 50 A.M.

21. I hereby certify that I attended the deceased from Aug 1st  
1944 to Oct 12, 1944  
that I last saw him alive on Oct 12, 1944  
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. CAROLINA CAMPANA

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased MARCH 8 1862  
(Month) (Day) (Year)

Immediate cause of death: Cerebral Neurosis  
Interoesophageal  
Chronic Interstitial Nephritis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 1510  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

<u>82</u>	<u>7</u>	<u>4</u>	_____ hr. _____ min.
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9. Birthplace SAVOUR ITALY  
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED

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

MOTHER FATHER { 12. Name UNKNOWN CAMPANA

13. Birthplace ITALY  
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace ITALY  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations ✓

Of autopsy ✓

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant A. Campana

(b) Address 651 W 70

17. (a) BURIAL (b) Date thereof OCT-14-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAL CEMETERY

18. (a) Signature of funeral director D. H. Williams, Inc.

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 10-13-44 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury ✓

23. Signature M. F. Howell (M. D. or other) MD

Address 1722 W 39 Date signed 10.12.44

1722 Walnut 39 & Abree

**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

*Cesar Torrey*

Licensed Embalmer No. *1767*

P. O. Address *Kansas City*

**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.**