

V. S. No. 2  
00M-5-43  
Rev. 5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8499**  
Registrar's No. **1324**  
**1257**

**FILED APR 5 1945**  
Registration District No. **149**

Primary Registration District No. **1002**

440  
328  
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:  
3827 EAST 59TH STREET  
(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 14 YEARS

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**3. (a) PRINT FULL NAME** MRS. HARRIET 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. ALBERT D. CAMPBELL 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased DECEMBER 18 1860  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>3</u>	<u>2</u>	_____ hr. _____ min.

9. Birthplace LYONS IOWA  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

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

**MOTHER FATHER**

12. Name JOHN TOLSON

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

14. Maiden name HARRIET SUMMERS CALES

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

16. (a) Informant MRS. HOLLIS C. STOUT  
 (b) Address 3827 EAST 59TH STREET

17. (a) REMOVAL (b) Date thereof MAR 22 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation STOCKTON KANSAS

18. (a) Signature of funeral director D. H. Newcomer Sons  
 (b) Address 1401 BRUSH CREEK BLYD.

19. (a) 3-22-45 (b) D. E. Brown  
(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. 3827 EAST 59TH STREET  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month MARCH day 20<sup>TH</sup>  
 year 1945 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from Mar 14, 1945 to Mar 20, 1945  
 that I last saw her alive on Mar 20, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Cerebral hemorrhage</u>	<u>10 days</u>
Due to <u>Arterio-sclerosis</u>	<u>about 10 yrs</u>
Due to _____	_____

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no  
 (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 E. W. Shusher (M. D. or other) \_\_\_\_\_  
 Address 900 North Bldg Date signed 3-21-45

PHYSICIAN  
Underline the cause to which death should be charged statistically.

900  
15-3  
Hesselsberg

**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 *E. Oscar H. May*

Licensed Embalmer No. 1767

P. O. Address Hesselsberg

**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.**