

FILED SEP 1 1945Registration District No. **149**Primary Registration District No. **1002**Registrar's No. **3482**

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:
R.C. GENERAL HOSPITAL NO. 10
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **12 DAYS**
 (Specify whether
 In this community **37 YEARS**
 years, months or days)

3. (a) PRINT FULL NAME **DR. WILLIAM THOMAS CAMPBELL**3. (b) If veteran,
name war **No**3. (c) Social Security
No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE**
 6. (a) Single, widowed, married, divorced **WIDOWED**
 6. (b) Name of husband or wife **MRS. LURA MAY CAMPBELL**
 6. (c) Age of husband or wife if alive **--** years
 7. Birth date of deceased **SEPTEMBER 22 1870**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	74	10	27	hr. min.

9. Birthplace **WAUTHENA KANSAS**
(City, town, or county) (State or foreign country)10. Usual occupation **PHYSICIAN**

11. Industry or business

12. Name **ADAM E. CAMPBELL**13. Birthplace **NEW YORK CITY, NEW YORK**
(City, town, or county) (State or foreign country)14. Maiden name **MINNIE E. BALDWIN**15. Birthplace **NORDHAUSEN GERMANY**
(City, town, or county) (State or foreign country)16. (a) Informant **MR. ADAM BURNS CAMPBELL**(b) Address **2460 CLEVELAND AVENUE**17. (a) **BURIAL** (b) Date thereof **AUG 22 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **BELMONT CEMETERY**18. (a) Signature of funeral director **W. H. Newcomer's Sons**(b) Address **1401 BRUSH CREEK BLYD.**19. (a) **8-20-45** (b) **Stearline Helmer**
(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. **2343 - CLEVELAND AVENUE**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **--**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **19TH**
year **1945** hour **2** minute **30 P. M.**21. I hereby certify that I attended the deceased from **8**
7, 19**45** to **8-19**, 19**45**
that I last saw him alive on **8-19**, 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**
Intertracheitic
fracture of right femur
 Due to **Intertracheitic**
fracture of right femur
 due to **Intertracheitic**
fracture of right femur

Other conditions
(Include pregnancy within 3 months of death) **1860-5**

Major findings:

Of operations **39**

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) **Accident**
 (b) Date of occurrence **8-7-45**
 (c) Where did injury occur? **K. C. Jackson, Mo.**
 (City or town) (County) (State)
 (d) Did injury occur at or about home, on farm, in industrial place, in public place?
Public place
 (Specify type of place) (Specify type of place)
 While at work? **Public place** (Specify type of place) (Specify type of place)
 Means of injury **fall**

23. Signature **Dr. W. H. Newcomer's Sons**
Gen. Hosp. Date signed **8-20-45**48
3
8

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 A C Newcomer Jr

Licensed Embalmer No. 4043

P. O. Address. A C Mo.

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.