

**FILED DEC 21 1945 STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_  
4964  
Registrar's No. \_\_\_\_\_

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:  
General Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 Days  
(Specify whether years, months or days)  
In this community About 16 years

**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. 1100 Park  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Wadie Campbell

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced unp

6. (b) Name of husband or wife Don't know 6. (c) Age of husband or wife if alive About 1872 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 73 Months Days If less than one day hr. min.

9. Birthplace Don't know Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Medical Records Librarian  
(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 12-4-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation First Baptist Church  
18. (a) Signature of funeral director First Baptist Church  
(b) Address \_\_\_\_\_

19. (a) 12-3-45 (b) W. Holmes  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month November day 24  
year 1945 hour 12 minute 45 A. M.

21. I hereby certify that I attended the deceased from November 17, 1945, to November 24, 1945, that I last saw her alive on November 24, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration \_\_\_\_\_

Due to Chronic Nephritis

Due to Hypertensive Heart Disease

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: 1318  
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? \_\_\_\_\_

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

23. Signature W. Holmes (M. D. or other)  
Address General Hospital #2 Date signed 11/24/45

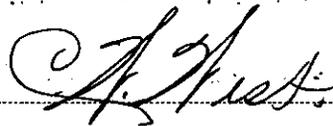
**STATEMENT BY LICENSED EMBALMER**

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. 2710

P. O. Address

K. C. M. D.

**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.**