

FILED NOV 15 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33890

STATE FILE NUMBER

 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4678

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7300 VIRGINIA AVE</u>			Length of stay in hospital <u>49 YEARS</u>		d. STREET ADDRESS (If outside, give location) <u>7300 VIRGINIA AVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>BURNS</u> Last <u>CAMPBELL, SR.</u>				4. DATE OF DEATH Month <u>10</u> Day <u>-27</u> Year <u>1956</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 21 - 1896</u>		
9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANUFACTURER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>SEMI-COLOR SPECIALTIES SILK-SCREEN PROCESSING</u>			11. BIRTHPLACE (City and state or country) <u>WATHENA KANSAS</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>								
13. FATHER'S NAME <u>DR. W. T. CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>LAURA MAY SMALL</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>7300 VIRGINIA K.C., MO.</u> <u>MRS. MARGARET R. LYDDEN CAMPBELL</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma (Reticulum cell type), widespread metastases</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							<u>2000</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition, Dehydration, Congestive heart failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>9-19-56</u> to <u>10-27-1956</u> and last saw him alive on <u>10-24-1956</u> Death occurred at <u>2:15</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Lawrence M. Field M.D.</u>				22b. ADDRESS <u>#815, 4620 S. C. Nichols Pkwy, K.C., Mo.</u>		22c. DATE SIGNED <u>10-27-56</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>OCT-30-1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. WASHINGTON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>		
24. FUNERAL DIRECTOR <u>D.W. NEUNCOMER'S SONS</u>		ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>10-30-56</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minchall</u>		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Lawrence M. Field

MEDICAL CERTIFICATION

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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 ....., Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Chester K. Bruce*

Licensed Embalmer No. *42*

P. O. Address.....  
*K.C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.