

# R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024497

8 FILED JUL 16 1959

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 119

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CLAY</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORTH KANSAS CITY</u> Length of stay in lb <u>14</u> DAYS c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MEMORIAL HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CLAY</u> c. CITY OR TOWN <u>KANSAS CITY, NORTH</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3002, Vivian Road</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>DeWitt</u> Middle <u>Clinton</u> Last <u>Campbell</u>			<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>7</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1/18/1890</u>	<b>9. AGE (last birthday)</b> <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Judge, Magistrate Court.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Berlin, Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		
<b>13a. FATHER'S NAME</b> <u>DeWitt Campbell Sr.</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Catherine Marsh</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Edna Belle Campbell</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.# 1</u>		<b>16. SOCIAL SECURITY NO.</b> <u>497.36.0697</u>		<b>17. INFORMANT</b> Address <u>Mrs. Edna Belle Campbell, 3002, Vivian Rd.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> (b) <u>Peritonitis</u> (c) <u>Pt. Colon Resection - + anastomosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>2-3 days</u> <u>14 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			
<b>20f. CITY, TOWN, OR LOCATION</b>		<b>20g. COUNTY</b>		<b>20h. STATE</b>			
<b>21. I attended the deceased from</b> <u>10-16-45</u> to <u>Death</u> and last saw her/him alive on <u>7-6-59</u> Death occurred on _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>M. Newcomers MS</u>			<b>22b. ADDRESS</b> <u>North KC. Mo</u>		<b>22c. DATE SIGNED</b> <u>7/9/59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>7/9/59</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Memorial Park Cemetery</u>			
<b>23d. LOCATION</b> (City, town, or county) <u>St. Joseph, Missouri.</u>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>D.W. NEWCOMERS SONS, North Kansas City, MO</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-8-59</u>			
<b>26. REGISTRAR'S SIGNATURE</b> <u>Marguerite Hudgens</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 22 1959

JUL 28 1959

VS MAY 18 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *John W. Hennick, Jr.*

Licensed Embalmer No. 4848

P. O. Address K. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

