

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-023482

FILED VS JUN 21 1960

146 3026 289

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b Life	c. CITY OR TOWN Independence Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Independence Sanitarium		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1625 N. Liberty Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LOLA Middle J. Last CAMPBELL		4. DATE OF DEATH Month June Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-13-1904
9. AGE (last birthday) 55		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	11. BIRTHPLACE (City and state or country) Pender, Nebraska
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME William Rogers	
13b. MOTHER'S MAIDEN NAME Bertie F. Lampson		14. NAME OF HUSBAND OR WIFE M. Paul Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address M. Paul Campbell 1625 N. Liberty Indep.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic adenocarcinoma throughout abdomen, chest & organs DUE TO (b) adenocarcinoma of ovary (left) & uterus DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 mo
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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 1956 to 6-9-60 and last saw her him alive on 6-9-60 . Death occurred at 10:25 p m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Vance E. Grabske & Link (Degree or title)		22b. ADDRESS 10901 Winner, Indep., Mo.	22c. DATE SIGNED 6-10-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-13-1960	23c. NAME OF CEMETERY OR CREMATORY Mound Grove	23d. LOCATION (City, town, or county) (State) Independence, Mo.
24. FUNERAL DIRECTOR Roland R. Speaks	ADDRESS Independence, Mo.	25. DATE RECD. BY LOCAL REG. 6-13-60	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 22 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 Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indep. W.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.