

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

30198

1: PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No.....
City St. Louis (No. City Hospital) St. Ward

2. FULL NAME

(a) Residence, No. 777 Capehaver St. W Ward.....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 19 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Pattie Capehaver</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec 18 - 1865</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>52</u>	<u>8</u>	<u>17</u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Conductor</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Daniel Capehaver

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER Elizabeth Moor

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT (Address) City Hospital

15. FILED Mar 6 Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 6 1920

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1920 to Sept 6, 1920.
(that I last saw him alive on Sept 6, 1920 and that death occurred, on the date stated above, at 1912 Ave)

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemiplegia (Old)
Pneumonia (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) Prostate (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? At
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) R. Frank M. D.
9/6, 1920 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla DATE OF BURIAL 9-8 1920

20. UNDERTAKER Arthur J. Donnelly ADDRESS 2039 Wash St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD

