

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

31763

4481

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Township Frank Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 City Kansas City (No. Wesley Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

George W. Capps  
 (a) Residence No. 37113 Euclid Sp. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of birth) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Eva L. Capps  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 13 - 1885  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
35 11 9  
 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work M. D.  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Woringer (STATE OR COUNTRY) Mo

10. NAME OF FATHER Lessie Capps  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Woringer Mo  
 12. MAIDEN NAME OF MOTHER Sarah M. Phetridge  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT Wm. S. Capps (Address) Woringer Mo

15. FILED 10/24, 19. 20 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 22 19 20  
 17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1920, to Oct 22, 1920, that I last saw h. alive on Oct 22, 1920, and that death occurred, on the date stated above, at 10:30 a. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Acute dilatation stomach  
115 - 105 (duration) yrs. mos. 3 ds.  
 CONTRIBUTORY (SECONDARY) Operation Youngman & Frudis (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) E. J. Conley M. B.  
10/23, 1920 (Address) 9115 Grand Ave KC Mo

\*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 Independence Mo DATE OF BURIAL Oct 24 19 20

20. UNDERTAKER Mrs C. L. Forster ADDRESS KC Mo

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.

