

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

Do not use this space.

Dr. Zeller
1157

1. PLACE OF DEATH
 County Greene Registration District No. 318
 Township Amoyfield mo Primary Registration District No. 2001
 City Elizabeth Kapp (No. _____) (St. _____ Ward _____)

2. FULL NAME Elizabeth Kapp
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (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 Female
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 8 - 1921
 7. AGE 8 YEARS MONTHS 0 DAYS 23
 If LESS than 1 day, hrs. or min.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Student
 (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) Mo
 10. NAME OF FATHER Ed Kapp
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo
 12. MAIDEN NAME OF MOTHER Lucie De Witt
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Iowa
 14. INFORMANT Ed Kapp
 (Address) Amoyfield mo
 15. FILED 2-1-29 (Date) Ob. Forest (Name) REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-31-1929
 17. I HEREBY CERTIFY, That I attended deceased from 1-17-1929, to 1-31-1929, 1929
 that I last saw her alive on 1-30-1929, 1929, and that death occurred, on the date stated above, at 9 am m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebro Spinal meningitis
115A
89A
79B (duration) yrs. mos. dx. ds.
 CONTRIBUTORY Infected Throat & Ear
 (SECONDARY) (duration) yrs. mos. dx. ds.
 18. WHERE WAS DISEASE CONTRACTED MIW
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) C. E. Zeller, M. D.
 (Address) Springfield 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.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lebanon mo DATE OF BURIAL 2-2-29
 20. UNDERTAKER W. H. Lohmeyer ADDRESS SPRINGFIELD, 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.
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