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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 42160

Township ..... Primary Registration District No. 1003 Registered No. 11867

City St Louis (No. 6456 Floyd St. ..... Ward)

2. FULL NAME Amelia Capelli

(a) Residence. No. ..... St., 4 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph J Capelli

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10 - 1882

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	46	11	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Hamburg
(STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER Otto Engmann

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

12. MAIDEN NAME OF MOTHER Paula Schoenburg

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

14. INFORMANT Joseph J Capelli
(Address) 6456 Floyd

15. FILED DEC -6 1929 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1929, to December 4, 1929, that I last saw her alive on Dec 4, 1929, and that death occurred, on the date stated above, at 1005 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis, Chr. Pulm
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Myocarditis, Chr
(duration) yrs. 2 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? X-Ray, & Sputum exam
(Signed) N C Miller, M. D.
, 19 (Address) 1889 Ry Exch Bldg.

*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	DATE OF BURIAL
Calvary	Dec 7 1929
20. UNDERTAKER	ADDRESS 4410
Harrigan & Sheahan Mrs Co	Washington

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.