

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

Do not use this space.

36099

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas

Registration District No. 399  
Primary Registration District No. 1002  
(No. 4540 Virginia)

File No. \_\_\_\_\_  
Registered No. 4502  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Alanson M. Capps  
(a) Residence. No. 4540 Virginia St. 12 Ward.

(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 widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 20, 1844

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<u>86</u>	<u>6</u>	<u>17</u>		

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Lamp lighter  
(b) General nature of industry, business, or establishment in which employed (or employer) Retired  
(c) Name of employer \_\_\_\_\_

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

<b>PARENTS</b>	10. NAME OF FATHER <u>Alanson Capps</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>
	12. MAIDEN NAME OF MOTHER <u>Molly Rose</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>

14. INFORMANT J. M. Capps  
(Address) 4540 Virginia

15. FILED 11/8/30 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 6 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 6, 1930 to Nov 6, 1930 that I last saw him alive on Nov 6, 1930, and that death occurred, on the date stated above, at about 7 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

arterio-sclerosis  
78  
11/6  
1930  
(duration) 25 yrs. mos. ds.

CONTRIBUTORY Senility  
(SECONDARY) (duration) \_\_\_\_\_ yrs. 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 clinical  
(Signed) J. L. Dod, M. D.

11/7 1930 (Address) 4611 Frost ave

\*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 Elmwood DATE OF BURIAL Nov-8 1930

20. UNDERTAKER Dwight McMeis Sons K.C.

Miss L. Smith  
No. 216 117