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.

SEP 15 1936

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

Do not use this space.

32385

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 8204

City St. Louis, Missouri (No. City Hospital No. 1 St. ..... Ward)

B. 2822 Mary Walters

2. FULL NAME .....

(a) Residence, No. 2510 South 10th St., 23 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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): widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Earnest Walters

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Sept. 14, 1869

7. AGE: ? Years: 66 Months: 10 Days: 20 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. hwk
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. at home
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois

FATHER

13. NAME: John Kapp
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

MOTHER

15. MAIDEN NAME: Caroline Hoffman
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

17. INFORMANT (ADDRESS): Hosp. Info. M.H.Kent City Hospital No. 1

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Matthews DATE Aug. 7, 1936

19. UNDERTAKER (ADDRESS): A. W. McLaughlin 2301 Lafayette Ave.

20. FILED AUG 5 1936 J. H. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 8/4/36, 19

22. I HEREBY CERTIFY, That I attended deceased from 5/25/36 19 to 8/4/36, 19 ..... I last saw her alive on 8/4/36, 19 ..... Death is said to have occurred on the date stated above, at 9.35 p m.

The principal cause of death and related causes of importance were as follows:

Empyema Results of Lobar Pneumonia

Date of onset

108

Other contributory causes of importance:

Name of operation Thoracotomy Date of 5-29-36

What test confirmed diagnosis? ..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19 .....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) S. M. Langdon, M. D.
(Address) City Hospital No. 1