

DEC 13 1937

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

39333
Do not use this space.
10320

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003** / Registered No.
(c) City. **St. Louis Mo** (d) Street No. **En route City Hospital #1** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Rose Margaret Kannapell**

(a) Residence, No. **4436 North 19th St.** St. **9** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept 26th 1912**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 **25** **1** **10**
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Clerk**
9. Industry or business in which work was done, as saw mill, bank, etc.
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) **St. Louis Mo**

FATHER 13. NAME **Frank Kannapell**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Missouri**

MOTHER 15. MAIDEN NAME **Elizabeth Holweck**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

17. INFORMANT **Mrs. Elizabeth Kannapell**
(ADDRESS) **4436 North 19th St.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Nov 8th 1937**

19. FUNERAL DIRECTOR **Stroot - Carroll**
(ADDRESS) **4600 Natural Bridge**

20. FILE NO. **NOV 6 1937** **J. F. Bredeck** Local Registrar.

NO PHYSICIAN IN ATTENDANCE

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Nov 5th 37**

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h..... alive on 19..... Death is said

to have occurred on the date stated above, at **4:40 A.M.**

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

Pulmonary Tuberculosis.

Other contributory causes of importance:

Name of operation Date of
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? **No.**
If so, specify

(Signed) **Joseph M. Deussen, M.D.**
(Address) **Deputy Coroner**

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.

STATEMENT BY LICENSED EMBALMER

I, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

..... L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed

Frank H. Short

Licensed Embalmer No. 2265

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)