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.

REC'D NOV 16 1938

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

3 791

33800
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 8786
(c) City St Louis (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 160 John Kapper
(a) Residence, No. 3614 N 14 Th Rear St. 26
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widower
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 14 Th 1863
7. AGE: 74 YEARS ----- MONTHS 11 -- DAYS 25 -- If LESS than 1 day, ... hrs. or ..... min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

FATHER
13. NAME John Kapper
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

MOTHER
15. MAIDEN NAME Not Knowen
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

17. INFORMANT (ADDRESS) Margareth Meister 4500 Dryon ave
18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cem. DATE Oct. 10 TH 38
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edward Koch 3516 N 14 Th St
20. FILED OCT 8 1938 19 J E Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/7/38 19
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 2:30 P.M.
The principal cause of death and related causes of importance were as follows:

Illuminating Gas Poison, self administered in his home at 3614 N. 14th Street, on October 7th, 1938 at about 2:30 P.M.

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of 760
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Suicide Date of injury 10/7/, 19 38
Where did injury occur? St. Louis, Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. In Home
Manner of injury See Above
Nature of injury 760
24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Joseph M. Queen, M.D.
(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No. 1591

P. O. Address 4106 [illegible] Potomac

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

If this body is not embalmed, above space should be left blank.