

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.

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

11815
Do not use this space.

REC'D APR 6 1939

1. PLACE OF DEATH
 (a) County Reynolds Registration District No. 1102
 (b) Township Paseath Primary Registration District No. 5870
 (c) City (d) Street No. 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. (f) How long in U. S., if of foreign birth? yrs. mos. da.
 2. PRINT FULL NAME Robert Eldridge Capps
 (a) Residence, No. St. (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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-22-1899

7. AGE YEARS 42 MONTHS 5 DAYS 9 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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) Clark'sdale (STATE OR COUNTRY) Miss

FATHER

13. NAME Daniel Chester Capps
 14. BIRTHPLACE (CITY OR TOWN) Don't know (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Mary Baker
 16. BIRTHPLACE (CITY OR TOWN) DK. (STATE OR COUNTRY)

17. INFORMANT Maurice Capps (ADDRESS) 3529 City of Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Gregory cemetery H-2 1939

19. FUNERAL DIRECTOR (NAME) H. L. Smith (ADDRESS) Carrollton Mo

20. FILED 4-30-1939 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-1-1939

22. I HEREBY CERTIFY, That I attended deceased from 3-12-1939 to 4-1-1939
 First saw him alive on 3-30-1939. Death is said to have occurred on the date stated above, at 8:30 a. m.,
 The principal cause of death and related causes of importance were as follows:
pulmonary T. B.
72
 Date of onset 6.6.38

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? E.T.S. 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) Arthur H. Smith, M. D.
 (Address) Keokuk, Mo.

OCT 29 1944

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.....

P. O. Address.....

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.)

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

11815
Do not use this space.

1. PLACE OF DEATH

(a) County Pemiscot Registration District No. 1107
 (b) Township Pascala Primary Registration District No. 5870 Registered No. _____
 (c) City _____ (d) Street No. _____ 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

Robert Eldridge Capps
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/1, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 3-15, 1939 to 4-1, 1939
 I last saw h. alive on 3-30, 1939. Death is said to have occurred on the date stated above, at 8 P. m.
 The principal cause of death and related causes of importance were as follows:

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
42 5 9

Pulmonary T. B.
 Date of onset _____

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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 _____

Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clarkdale, Miss.

FATHER 13. NAME Daniel Webster Capps

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME Mary Baker

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Vicksburg

17. INFORMANT (ADDRESS) Marguerite Capps
Greasy City, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Greasy City DATE 4-2, 1939

19. FUNERAL DIRECTOR (ADDRESS) H. S. Smith
Camthersville, Mo

20. FILE July 17, 1939 Mrs T. R. Cole
Local Registrar //

Name of operation _____ Date of _____
 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? _____ 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) A. G. Shirey, M. D.
 (Address) Hayti, Mo

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

TEMPORARILY

MAY 27 1954