

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **6738**

1. PLACE OF DEATH: **DECD SEP 14 1939**
(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution: **1214 Blackstone**
(d) Length of stay: In hospital or institution **X**

In this community _____ years, months or days

3. (a) PRINT FULL NAME **William Kappelman**

3. (b) If veteran, name war **X** 3. (c) Social Security No. **X**

5. Color or race **Male** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Ann Kappelman** 6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **Jan 18 1868**

8. AGE: Years **71** Months **6** Days **27** If less than one day **—** hr. **—** min.

9. Birthplace **St. Louis**

10. Usual occupation **Auto trimmer**

11. Industry or business **Dorris Motor Co.**

12. Name **John Kappelman**

13. Birthplace **Barnum**

14. Maiden name **Wilhelmina Kappelman**

15. Birthplace **Barnum**

16. (a) Informant's own signature **Ann Kappelman**

(b) Address **1214 Blackstone**

17. (a) **Burial** (b) Date there **Aug 2 1939**

(c) Place: burial or cremation **Galveston**

18. (a) Signature of funeral director **Chas. F. Stewart**

(b) Address **1225 Union Blvd**

19. (a) **AUG 1 1939** (b) **J. P. Bredeck**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **St. Louis**
(c) City or town **St. Louis**
(d) Street No. **1214 Blackstone**
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **31** year **1939** hour **7** minute _____ M.

21. I hereby certify that I attended the deceased from **July 29** to **July 31**, 19**39**, that I last saw him alive on **July 29** and that death occurred on the date and hour stated above.

Immediate cause of death **6 home Myocarditis**

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: **no**

Of operations: **no**

Of autopsy: **no**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____ (e) Means of injury _____

23. Signature **Wm J. Langan Jr.** (M. D. or other) _____

Address **5803 Plymouth av** Date signed **Aug 1/39**

Duration

24 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 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

J. S. Sullivan

Licensed Embalmer No. 4122

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.