

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No.

801

Registrar's No.

801

Registration District No.

791

Primary Registration District No.

1003

1. PLACE OF DEATH:

FILED FEB 17 1940 /

(a) County.....
(b) City or town..... St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Bethesda Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME William A. Capps 12-5

3. (b) If veteran, name war..... No
8. (c) Social Security No. None

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

6. (b) Name of husband or wife..... Avia Capps
6. (c) Age of husband or wife if alive..... 50 years

7. Birth date of deceased..... 3 ? 1886.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 hr. min.

9. Birthplace..... Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Watchman

11. Industry or business.....

12. Name Alfred Capps

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Avia Ausbach
(City, town, or county) (State or foreign country)

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. D. Capps

(b) Address 6128 A Bartmer Ave.

17. (a) Burial (b) Date thereof Jan 27, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laurel Hill Cem.

18. (a) Signature of funeral director Jos W. Clark

(b) Address 1125 Hodiamont Ave

19. Jan 23 1940 (b) J. F. [Signature]
(Date of registration) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town..... Wellston NR
(If outside city or town limits, write "RURAL")
(d) Street No. 6509 Easton Ave
(If rural, give location)
No Physician in Attendance
(e) If foreign born, how long in U. S. A. ?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 24
year 1940 hour 4 minute 00 A. M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Tobac Pneumonia

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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?

While at work..... (Specify type of place) (e) Means of injury.....

23. Signature Joseph M. [Signature] (M. D. or other)
Address Deputy Coroner

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

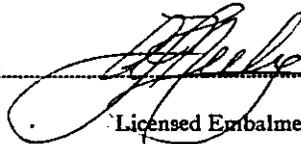
N. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....



Licensed Embalmer No. 3225

P. O. Address 1125 Hodiament Ave

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.