

No. 2
-10-39
17-39
X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16592**
Registrar's No. **4070**

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **ST. LOUIS**
(c) Name of hospital or institution: **DE PAUL HOSPITAL**
(d) Length of stay: In hospital or institution **3 DAYS**
In this community _____ years, months or days

3. (a) PRINT FULL NAME **ELIZABETH KAPPEL** **140**
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **JOSEPH KAPPEL** 6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased **DONT KNOW** **1882**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
abt 58 **DONT KNOW** hr. min.

9. Birthplace **ST. LOUIS MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business _____
12. Name **JOHN FARRELL**
13. Birthplace **IRELAND**
14. Maiden name **JOHANNA SULLIVAN**
15. Birthplace **IRELAND**

16. (a) Informant **JOSEPH KAPPEL**
(b) Address **6137 WATERMAN AVE.**

17. (a) **BURIAL** (b) Date thereof **5-7-40**
(c) Place: burial or cremation **CADVAERY CEMETERY**

18. (a) Signature of funeral director **W. H. ...**
(b) Address **3840 LINDELL BLVD.**

19. (a) **MAY 6 1940** (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO.** (b) County _____
(c) City or town **ST. LOUIS**
(d) Street No. **6137 WATERMAN AVE.**
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **MAY** day **FOURTH**
year **1940** hour **12** minute **30** P. M.

21. I hereby certify that I attended the deceased from **Nov 1939** to **May 7 1940**
that I last saw him alive on **May 4 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction 8 yrs**
Cardio. Vasculop. Disease
Due to **Disease of Heart**
Due to **Coronary Arteriosclerosis**

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations: _____
Of autopsy: _____
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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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Special type of place)
(e) Means of Injury _____
23. Signature **W. H. ...** (M. D. or other) **5/6/40**
Address **Union Club St.** Date signed

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

University
J.M. 1534
1-3
Clark

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell Bl

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

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