

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29056

Registration District No. 538

Primary Registration District No. 6724

Registrar's No. 50

1. PLACE OF DEATH:
(a) County Madison
(b) City or town St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(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 115

3. (a) PRINT FULL NAME James V. Capeland
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex M. 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Emma Capeland
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Jan. 22 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 6 18 hr. min.

9. Birthplace Madison Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Wm Capeland
13. Birthplace Madison Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Jane Frey
15. Birthplace Madison Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]
(b) Address Federicktown Mo.

17. (a) Burial (b) Date thereof Aug. 10-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little York
18. (a) Signature of funeral director [Signature]
(b) Address Federicktown Mo.

19. (a) Aug 10 - 1940 (b) S. C. J. Laughlin
(Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Madison
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. St. Francois
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 10
year 4 hour 15 minute 9 A. M.
21. I hereby certify that I attended the deceased from July 22
1940 to August 18, 1940
that I last saw him alive on August 3, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Broncho pneumonia
Due to Aspirate Stools
Due to Central Nervous Sys.

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations [Signature]
Of autopsy [Signature]

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(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? Yes

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Harold Greer (M. D. or other) MD
Address Federicktown Mo Date signed Aug 10

Duration 4 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.....

was not embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Ed. Hill Cobb

Licensed Embalmer No.....

731

P. O. Address.....

Frederick Brown

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.