

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.

**OCT 12 1940**  
Registration District No. **24**

Primary Registration District No. **3009**

Registrar's No. **314**

1. PLACE OF DEATH:  
 (a) County Cape Girardeau  
 (b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
702 N. St.  
(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

8. (a) PRINT FULL NAME EDWARD W. FLENTOE  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 6. (b) Name of husband or wife Capitola 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased March 2, 1863  
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Tobacco mfg.

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Unknown  
 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Capitola Flentoe  
 (b) Address 702 N. St. Cape Girardeau

17. (a) Burial (b) Date thereof Sept 15-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parsonage Cape Girardeau  
 18. (a) Signature of funeral director Burkhardt & Howell  
 (b) Address 536 E. Brady Cape Girardeau

19. (a) 9-14-40 (b) J. M. Thompson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Cape Girardeau  
 (c) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 702 N. St.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept. day Friday 13<sup>th</sup>  
 year 1940 hour 3:30 minute AM M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 1937 to Sept. 13 1940;  
 that I last saw him alive on Sept. 13 1940;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Calculus Duration \_\_\_\_\_

Due to Nephritis Chronic

Due to \_\_\_\_\_

Other conditions Mild regurgitation  
(Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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 C. W. Kinsey (M. D. or other) D.O.  
 Address Cape Girardeau Date signed 9/14/40

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**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.**