

Registration District No. 12 Primary Registration District No. 5440

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Medical Center for Federal Prisoners  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 months 3  
(Specify whether years, months or days)  
In this community 3 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Alabama (b) County Walker  
(c) City or town Jasper  
(If outside city or town limit, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 24th,  
year 1940 hour 8:00 minute A. M.  
21. I hereby certify that I attended the deceased from July 23, 1940  
to Oct. 24, 1940  
that I last saw him alive on October 24th, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Duration Since Adm. 2 yrs.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Syphilis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Chronic Myocarditis  
PHYSICIAN \_\_\_\_\_  
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? NO (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature E. W. Green M.D. (M. D. or other) \_\_\_\_\_  
Address Clinical Director MCFP Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME CAPEL L, Sandy  
3. (b) If veteran, name war None 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced (C-L-Wife)  
6. (b) Name of husband or wife Emma Williams (C-L) 6. (c) Age of ~~husband~~ or wife if alive unknown years  
7. Birth date of deceased January 1, 1898  
(Month) (Day) (Year)

8. AGE: Years 42 Months 9 Days 23 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Coal Miner

11. Industry or business Unknown

MOTHER FATHER { 12. Name Sandy Capell  
13. Birthplace Unknown Unknown  
(City, town or county) (State or foreign country)  
14. Maiden name Rona (DK) Capell  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Deceased

(b) Address \_\_\_\_\_

17. (a) Removal (b) Date thereof 10-25-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jasper, Alabama

18. (a) Signature of funeral director W. E. Handley M.D.

(b) Address Springfield Mo.

19. 10-25-40 (Date received local registrar) (c) W. E. Handley M.D. (Registrar's signature)

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

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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.

X