No. 2
-1-4-41
5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27248

Registration District No. 1002 SEP 12 1941

Primary Registration District No. 1002

Registrar's No. 2906

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

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 8 Days (Specify whether years, months or days)
In this community: 29 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Jackson 48

(c) City or town: Kansas City 5
(If outside city or town limits, write "RURAL")

(d) Street No.: 5800 East 27th. 8
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Elma M. Capps

3. (b) If veteran, name war: No

3. (c) Social Security No.: No.

4. Sex: Fe.

5. Color or race: Wh.

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Oscar E. Capps

6. (c) Age of husband or wife if alive: 57 years

7. Birth date of deceased: July (Month) 12 (Day) 1882 (Year)

8. AGE:

Years	Months	Days	If less than one day
59	0	19	hr. min.

9. Birthplace: Keokuk Co. (City, town, or county) / Iowa (State or foreign country)

10. Usual occupation: Home

11. Industry or business:

FATHER
12. Name: Chas. W. Farmer
13. Birthplace: Keokuk Co. (City, town, or county) / Iowa (State or foreign country)

MOTHER
14. Maiden name: Mary A. Atwood
15. Birthplace: Keokuk (City, town, or county) / Iowa (State or foreign country)

16. (a) Informant: Mrs. Frank D. Smith
(b) Address: 5034 Park Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8-1-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Sigourney Iowa

18. (a) Signature of funeral director: Eylar Funeral Home
(b) Address: 1800 Linwood K.C.Mo.

19. (a) 8/1/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31st. year 1941 hour one minute 5 P.M.

21. I hereby certify that I attended the deceased from 7/21/41, 19..., to 7/31/41, 19...; that I last saw h. alive on 7/31/41, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Heart Failure	
Toxic Regurgitation	
Due to: Cardiac Dilatation	
Hypertension	
Due to: Arteriosclerosis	
Other conditions (Include pregnancy within 3 months of death): —	
Major findings: Of operations: —	
Of autopsy: Aortic Valvular Disease Pericardial & Pleural Effusion	

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

23. Signature: Leonard Oeding (M. D. or other) O
Address: 3548 Swanson ave. Date signed: 8/1/41

(Licensed Embalmer's Statement on Reverse Side)

Argyle Bldg. Vi 8227
2718 Le. 0652
Linwood

Rs 7611

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 Chas. Wilks

Licensed Embalmer No. 2644

P. O. Address 1800 Linwood

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

If this body is not embalmed, fact should be so stated above.