

FILED APR 10 1945

Registration District No. 47

Primary Registration District No. 3008

14
1
20

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton

(c) Name of hospital or institution State Hosp # 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-14-45
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Frank Cappel

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 2 24 1856
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>89</u>		<u>27</u>	hr. _____ min. _____

9. Birthplace Ill. 1
(City, town, or county) (State or foreign country)

10. Usual occupation WTC

MOTHER FATHER

11. Industry or business _____

12. Name Casper Cappel

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Germany

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Record State Hospital

(b) Address Fulton

17. (a) Burial (b) Date thereof Mar 25 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rothin Ell.

18. (a) Signature of funeral director Hackman-Bauer

(b) Address St. Charles, Mo.

19. (a) 3-23-1945 (b) Joan Mouschloff
(Date received local registrar's) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Charles

(c) City or town St. Charles 14
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No) 2
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 23
year 1945 hour 11 minute 20 a.m.

21. I hereby certify that I attended the deceased from 2-14-1945 to 3-23-1945
that I last saw him alive on 3-23-1945
and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis Duration _____

Dr. Curtis Selman

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 93d

Of autopsy _____

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? _____ (Specify type of place)

(e) Means of injury _____

23. Signature H. E. Starnell (M. D. or other) _____
Address Fulton MO 3/23/45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed: 4-9-45

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: Glen Y. Maupin

Licensed Embalmer No. 2725

P. O. Address: Fulton, Mo.

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, fact should be so stated above.