DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10136

FILED APR 10 1947

Registration District No. 247 | Primary Registration District No. 5839 | Registrar's No. 12

1. PLACE OF DEATH:
(a) County: NEWTON
(b) City or town: RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: GRANBY TWP.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: NEWTON
(c) City or town: RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. GRANBY TWP.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: MOLLIE LENA CAPPS.
3. (b) If veteran, name war: NONE
3. (c) Social Security No. NONE
4. Sex: FEM
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: SINGLE
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: FEBRUARY (Month) 10 (Day) 1902 (Year)

8. AGE: Years 45 | Months 1 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace: NEWTON Co. (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation: AT HOME
11. Industry or business ____
12. Name (FATHER): JAMES M. CAPPS.
13. Birthplace (FATHER): NODAWAY Co. (City, town, or county) MISSOURI (State or foreign country)
14. Maiden name (MOTHER): MATTIE JANE HUTCHINSON
15. Birthplace (MOTHER): NEWTON Co. (City, town, or county) MISSOURI (State or foreign country)
16. (a) Informant's own signature: J. M. Capps
(b) Address: Joplin Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Oakwood Cem.
18. (a) Signature of funeral director: Corley Thompson
(b) Address: Neosho Mo.
19. (a) 3-28-47 (Date received local registrar) (b) M L Young (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 17 year 1947 hour 12:20 minute P. M.

21. I hereby certify that I attended the deceased from ____, 19__, to March 16, 1947; that I last saw her alive on March 16, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Diabetic coma	
Due to: Diabetis	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
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: C. E. Manesa (M. D. or other) MD
Address: Neosho Mo. Date signed 3-27-47

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Rev. 5-[illegible] 1 X19511

RECEIVED
District Health Officer No. Newton
District File Number 447-26
Date Filed 4-8-47

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 Corley Thompson

Licensed Embalmer No. 3259

P. O. Address Neosho 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, above space should be left blank.