6. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 23 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22380

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 5711

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: FIRMIN DESLOGE HOSP O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 YEARS (Specify whether years, months or days)
In this community 9 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County

(c) City or town CHILLICOTHE MO
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Kappus, Flora

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex F

5. Color or race W

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

6. (b) Name of husband ~~or wife~~ CHARLES KAPPUS

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

7. Birth date of deceased AUG (Month) 12 (Day) 1862 (Year)

8. AGE: Years 84 | Months 9 | Days 26 | If less than one day 15 hr. 30 min.

9. Birthplace BUFFALO (City, town, or county) NEW YORK (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name CHARLES IGNATIUS SWANT
13. Birthplace UNKNOWN (City, town, or county) ILLINOIS (State or foreign country)

MOTHER
14. Maiden name GRACE MEYER
15. Birthplace BUFFALO (City, town, or county) NEW YORK (State or foreign country)

16. (a) Informant Sister Mary Florentine
(b) Address Firmin DeLoge Hosp

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 12-1947 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ CHILLICOTHE MO

18. (a) Signature of funeral director Watson Bookings
(b) Address 6536 Clayton Rd

19. (a) JUN 10 1947 (Date received local registrar) (b) J. F. Breneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8 year 1947 hour 2 minute 40 P. M.

21. I hereby certify that I attended the deceased from 5-17 19.47 to 6-8 19.47; that I last saw her alive on 6-7 19.47 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral embolism	3 weeks
Gangrene of the left lower extremity	
Due to: Generalized arteriosclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: Amputation of left at above extremity and chest
~~Of autopsy~~: Date May 17, 1947

PHYSICIAN — Underline the cause of 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 Gerard J. Uhrich (M. D. or other) M.D
Address 1325 So Grand Blvd Date signed 6-8-47
Gerard J Uhrich

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 J. Allen Davis Jr

Licensed Embalmer No. 4053

P. O. Address St Louis 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.