

No. 2  
1/47  
5-17-39

1627  
189  
State File No.  
Registrar's No.

National Office of Vital Statistics  
FILED FEB 11 1948

Registration District No. 170

Primary Registration District No. 3033

1. PLACE OF DEATH  
(a) County Laclede  
(b) City or town Lebanon, Mo.  
(c) Name of hospital or institution: Walden Hosp.  
(d) Length of stay: In hospital or institution 74 yrs.  
In this community 74 yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Laclede 53  
(c) City or town Rural  
(d) Street No. Lebanon Mo RR. 3  
(e) Citizen of foreign country? (Yes or No) No  
If yes, name country

3. (a) PRINT FULL NAME Louise KAPP  
3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive 36 years (Day) (Year) 1857  
7. Birth date of deceased Dec. 26 1857  
(Month) (Day) (Year)

8. AGE: Years 90 Months 0 Days 26 If less than one day br. min.

9. Birthplace N.Y. City (City, town, or county) N.Y. (State or foreign country)

10. Usual occupation at home

11. Industry or business  
12. Name Andrew Kapp 4  
13. Birthplace Germany  
14. Maiden name Sophia Kats  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Ed Kapp  
(b) Address Lebanon Mo

17. (a) Burial (b) Date thereof 11/23/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lebanon Mo

18. (a) Signature of funeral director Palmer  
(b) Address Lebanon Mo

19. (a) 2-14-48 (b) U. S. S. I. C. 44217  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 21  
year 1948 hour 5 minute 08 A.M.

21. I hereby certify that I attended the deceased from 1/12 1948, to 1/21 1948  
that I last saw her alive on 1/21 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death hypostatic pneumonia 20 hrs  
Due to intertrochanteric fracture  
Due to right femur 9 days

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 10/6 A  
Of autopsy 1/18  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
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 53  
(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 11  
23. Signature James P. Lopez (M. D. or other) A  
Address Lebanon, Mo Date signed 1/22/48

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

MOTHER FATHER

Received 2/10/48  
County Health Unit  
1-48-12  
Date filed 2/10/48

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 P. L. Palmer  
Registered Apprentice No. 84  
working under my personal supervision.

Signed P. L. Palmer  
Licensed Embalmer No. 2207  
P. O. Address Albany, 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.

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Registration District No. 170 Primary Registration District No. 0023

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

1. PLACE OF DEATH: Lochside, Lebanon

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

3. (a) PRINT FULL NAME: Louise Kapp

3. (b) If veteran, name war..... 3. (c) Social Security No. ....

4. Sex: F 5. Color or race: W 6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive: 26 years

7. Birth date of deceased: Dec 26 (Month) 1921 (Year)

8. AGE: Years 90 Months 0 Days 0 If less than one day: 0 hr. 0 min.

9. Birthplace: N.Y. (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

{ 14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 2/14/48 (Date received local registrar) (b) Louise Kapp (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day..... Year 1948 Hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that I last saw him..... alive on..... and that death occurred on the date and hour stated above. Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
 Of operations.....

Of autopsy.....

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..... (M. D. or other)  
 Address..... Date signed.....

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