

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27883**
Registrar's No. **7112**

FILED AUG 23 1948
Registration District No. **008**

Primary Registration District No. **1003**

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: **De Paul Hospital**
(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 **Emma Olinda Kapp**

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

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Charles H. Kapp** 6. (c) Age of husband or wife if alive **56** years
7. Birth date of deceased **June 21 1891**
(Month) (Day) (Year)

8. AGE: Years **57** Months **1** Days **21** If less than one day hr. _____ min. _____

9. Birthplace **St. Louis** **Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Home**

11. Industry or business _____

12. Name **Henry Sohler**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Henrietta Moeller**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles Kapp**
(b) Address **4960 Northland Ave.**

17. (a) **burial** (b) Date thereof **8-16-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Bethlehem**

18. (a) Signature of funeral director **Drehmann-Haral**

(b) Address **1905 Union Blvd.**

19. (a) **AUG 13 1948** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4960 Northland Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **12**
year **1948** hour **1** minute **30** P. M.

21. I hereby certify that I attended the deceased from **Aug 11**, 19**48**, to **Aug 12**, 19**48**,
that I last saw her alive on **Aug 12**, 19**48**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Hemorrhagic Pancreatitis** Duration **30 hrs**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **1/2/48**

Major findings: Of operations _____
Of autopsy **Acute hemorrhagic Pancreatitis**
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 **J. M. Shaner** (M. D. or other) _____
Address **3720 Washington** Date signed **8/13/48**

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Albert R. Thompson

Licensed Embalmer No.

P. O. Address.....

St. Louis

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.