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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 1 1948

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 36431

Registrar's No. 4532

1. PLACE OF DEATH:

(a) County: Jackson

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

(c) Name of hospital or institution: Kansas City General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 36 hours (Specify whether years, months or days)

In this community: 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 1120 Wyandotte - Rasbach Hotel 8
(If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: Joseph Capps

3. (b) If veteran, name war: Unknown

3. (c) Social Security No.: Unknown

4. Sex: M 0

5. Color or race: White

6. (a) Single, widowed, married, divorced: Single 0

6. (b) Name of husband or wife:

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

7. Birth date of deceased: Nov. (Month) 16 (Day) 1902 (Year)

8. AGE: Years 46 Months 11 Days 21 If less than one day: hr. min.

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

10. Usual occupation: Druggist

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant: Record Clerk 1

(b) Address: K.C. General Hosp. #1

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 11-7-48 (Month) (Day) (Year)

(c) Place: burial or cremation: Arcadia, Kansas

18. (a) Signature of funeral director: Weilert Funeral Home

(b) Address: 2332 Monitor Place: K.C. Mo.

19. (a) 11-7-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 7th year 1948 hour 11 minute 15 AM.

21. I hereby certify that I attended the deceased from November 5, 1948 to November 7, 1948 that I last saw him alive on November 7, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute liver failure with pneumonia bronchial	
Due to: fatty degeneration of liver alcoholism	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: None	

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? (Specify type of place) While at work? (e) Means of injury: 0

23. Signature: Wm. W. Hart M.D. (M. D. or other)

Address: Med. Dir. General Hospital #1 Date signed: 11-7-48

(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 Blaine E. Weilert

Licensed Embalmer No. 4075

P. O. Address K.C. 8, 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.