

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31650**
8594

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN St. Louis)	c. LENGTH OF STAY (in this place) township)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	VI 4
d. FULL NAME OF HOSPITAL OR INSTITUTION 911 Buchanan		d. STREET ADDRESS (If rural, give location) 911 Buchanan	

3. NAME OF DECEASED (Type or Print)	a. (First) Liza	b. (Middle) Ann	c. (Last) Cape	4. DATE OF DEATH (Month) (Day) (Year) Oct. 4th 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 8, 1888	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Texas Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME John Wells	13b. MOTHER'S MAIDEN NAME Sis Stringer	14. NAME OF HUSBAND OR WIFE Lawrence Cape
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Lawrence Cape	ADDRESS 911 Buchanan
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		2 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Bronchitis		5 yrs
DUE TO (c) General Debility		2 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis		2 yrs	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 112
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 5021
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22. I hereby certify that I attended the deceased from **1949, to Oct. 4th, 1949**, that I last saw the deceased alive on **Oct 4th, 1949**, and that death occurred at **3:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Nicholas Klym M.D.	23b. ADDRESS 1116 Salceburg	23c. DATE SIGNED 10-5-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-5-49	24c. NAME OF CEMETERY OR CREMATORY Emery	24d. LOCATION (City, town, or county) (State) Texas Co., Mo.
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DATE REC'D BY LOCAL REG. OCT 5 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed

J. Wm. Binkley
1 - _____

Licensed Embalmer No. 363

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.