No. 300
10-48

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 38904

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10378

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place): 4 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 3400 S. Grand Blvd.

16 2160

**3. NAME OF DECEASED** (Type or Print)
a. (First): Frank
b. (Middle):
c. (Last): Kappes

**4. DATE OF DEATH** (Month) (Day) (Year): November 14, 1954

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Single
**8. DATE OF BIRTH**: June 29, 1864
**9. AGE** (In years last birthday): 90 — If under 1 year: Months 4, Days 15; If under 1 day: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Shoemaker
**10b. KIND OF BUSINESS OR INDUSTRY**: Retired
**11. BIRTHPLACE** (City and State or Foreign Country): St. Louis, Mo.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13a. FATHER'S NAME**: Frank Kappes
**13b. MOTHER'S MAIDEN NAME**: Theresa Stinger
**14. NAME OF HUSBAND OR WIFE**:

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown)
(If yes, give war or dates of service)
**16. SOCIAL SECURITY NO.**: none
**17. INFORMANT'S SIGNATURE OR NAME**: Sister Henry
**ADDRESS**: 3400 S. Grand Blvd.

**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**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Congestive Heart Failure~~ STROKE — INTERVAL BETWEEN ONSET AND DEATH: ~~[illegible]~~ 1 day

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerosis — years
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.*

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION**
**20. AUTOPSY?** YES ☐ NO ☐

**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)**

**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

4500

22. *I hereby certify that I attended the deceased from* 11/7/54, 19__, *to* 11/14, 19__, *that I last saw the deceased alive on* 11/14/54, 19 54, *and that death occurred at* 7:30 P m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): [signature]
**23b. ADDRESS**: 401 University Club
**23c. DATE SIGNED**: 11/15/54

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: 11/16/54
**24c. NAME OF CEMETERY OR CREMATORY**: St. Peter & Paul Cemetery
**24d. LOCATION** (City, town, or county) (State): St. Louis Mo.

**DATE REC'D BY LOCAL REG.**: NOV 15 1954
**REGISTRAR'S SIGNATURE**: J Carl Smith MD
mJB
**25. FUNERAL DIRECTOR'S SIGNATURE**: John H. Gebken Sons
**ADDRESS**: 2630 Gravois Ave.

(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 embal

by me, or by ....., Student Embalmer No.....

working under my personal supervision:.

Student.....
Signature of Student Embalmer

Signed Robert F. Gebh

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois A

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fai to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.