

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED DEC 30 1957

43507  
 STATE FILE NUMBER  
 Registrar's No. 1383

Registration District No. 42 Primary Registration District No. 1000

V. S. 300  
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp.		d. STREET ADDRESS 1105 Henry	
3. NAME OF DECEASED (Type or print) First Middle Last ALLIE E CAPLES		4. DATE OF DEATH Month Day Year Dec. 13 1957	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Home	
13a. FATHER'S NAME Marion Caples		13b. MOTHER'S MAIDEN NAME Elizabeth Perkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 558-28-5622	
17. INFORMANT Mrs. C. D. Gomel		Address St. Joseph, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease			Unk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		4200	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 12/11/57 to 12/13/57 and last saw her alive on 12/12/57 Death occurred at 10:10A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Queen W. Slattery MD		22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.	
22c. DATE SIGNED 12/14/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-16-57	
23c. NAME OF CEMETERY OR CREMATORY Amazonia Cemetery		23d. LOCATION (City, town, or county) (State) Amazonia Missouri	
24. FUNERAL DIRECTOR Honey Funeral Home		ADDRESS St. Joseph, Mo.	
25. DATE RECD. BY LOCAL REG. Dec. 20, 1957		26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 ..... Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St. Joseph M

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

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