

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002638  
STATE FILE NUMBER

FILED FEB 11 1959 Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Oran</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #4</b>		Length of stay in 1b <b>35Y;3M;5das.</b>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAGGIE (MARGARET) KAPFER</b>			4. DATE OF DEATH Month Day Year <b>Jan. 4, 1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1878</b>		9. AGE (In years last birthday) <b>80</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Oran, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Peter LeGrand</b>		13b. MOTHER'S MAIDEN NAME <b>Josephine Bolver</b>		14. NAME OF HUSBAND OR WIFE <b>Oswald Kapfer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Records, State Hospital No. 4, Farmington, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia, right lower</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Abt. 48 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____					H90XA
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition since 1-29-58 <b>Dementia Praecox Psychosis for 35 yrs. and pulmonary tuberculosis</b>					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.					
20d. INJURY OCCURRED WHILE AT WORK <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 <b>Jan. 3, 1959</b> to <b>Jan. 4, 1959</b> and last saw her alive on <b>Jan. 4, 1959</b> Death occurred at <b>1:10 A. M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>J. A. Brennan M.D.</i>			22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>		22c. DATE SIGNED <b>Jan. 4, 1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 7, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old Guardian Angels</b>		23d. LOCATION (City, town, or county) (State) <b>Oran, Missouri</b>
24. FUNERAL DIRECTOR <b>Earl J. Smith, Funeral Home, Oran, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Feb 3, 1959</b>		26. REGISTRAR'S SIGNATURE <i>Cather Rudloff</i>	

(Licensed Embelmer's Statement on Reverse Side)

health, Welfare Public Service  
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 -57  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 All diseases in Part I must be causally related.

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 *Eugene L. Tubbs* .....

Licensed Embalmer No. *5012* .....  
P. O. Address *Oran, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.