

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022568

STATE FILE NUMBER

FILED JUL 1 1959 Registration District No. 314 Primary Registration District No. 4439 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Osceola		c. CITY OR TOWN Humansville	
c. FULL NAME OF HOSPITAL OR INSTITUTION Osceola Medical Hospital		d. STREET ADDRESS (If outside, give location) 0840	
3. NAME OF DECEASED (Type or print) Arthur Benton Capps		4. DATE OF DEATH Month 6 Day 25 Year 1959	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 72
13a. FATHER'S NAME William		13b. MOTHER'S MAIDEN NAME Rebecca Milsap	14. NAME OF HUSBAND OR WIFE Martha
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. 491-42-8052	17. INFORMANT Address Mrs. Martha Capps, Humansville, 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) Meningitis DUE TO (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4500			INTERVAL BETWEEN ONSET AND DEATH 14 days years
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 _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from Death occurred at 4:30 6/21/59 P.		and last saw him alive on 6/25/59 on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Harold M. ... MD		22b. ADDRESS Osceola, Mo	
22c. DATE SIGNED 6/26/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/28/1959	
23c. NAME OF CEMETERY OR CREMATORY Freeman Cemetery		23d. LOCATION (City, town, or county) (State) St. Clair, Missouri	
24. FUNERAL DIRECTOR ADDRESS Beckwith Funeral Home, Humansville, Mo.		25. DATE RECD. BY LOCAL REG. 6-27-59	
		26. REGISTRAR'S SIGNATURE Ruth Seewer	

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 *O. H. Beckwith*

Licensed Embalmer No. *3937*
P. O. Address *Humansville*

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.