URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-008446

FILED VS FEB 25 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1671

STATE FILE NUMBER

NDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri COUNTY Franklin

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis 10, Mo. — Length of stay in 1b 7 weeks

c. CITY OR TOWN New Haven — Inside Limits Yes X No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp. — Inside Limits Yes X No ☐

d. STREET ADDRESS (If outside, give location) Main Street — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First HENRY Middle WILLIAM Last KAPPELMANN

4. DATE OF DEATH Month February Day 11 Year 1960

5. SEX Male

6. COLOR OR RACE White

7. Married X Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH $4/14/1871

9. AGE (last birthday) 88 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant

10b. KIND OF BUSINESS OR INDUSTRY Hardware

11. BIRTHPLACE (City and state or country) Dissen, Missouri

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME William Kappelmann

13b. MOTHER'S MAIDEN NAME Charlotta Krusebrink

14. NAME OF HUSBAND OR WIFE Marie nee Kies

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.

17. INFORMANT Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Brain hemorrhage due to rupture of arteriosclerotic brain artery

INTERVAL BETWEEN ONSET AND DEATH 3 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) ~~Generalized arteriosclerosis~~

DUE TO (c) 331x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic brain syndrome

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1-2-60, to 2-11-60 and last saw her/him alive on 2-11-60

Death occurred at 6:45 a.m. CST m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. J. Cath M.D.

22b. ADDRESS 634 N. Grand Blvd.

22c. DATE SIGNED 2/11/60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 2/14/60

23c. NAME OF CEMETERY OR CREMATORY Beouff Cem

23d. LOCATION (City, town, or county) (State) New Haven, Mo.

24. FUNERAL DIRECTOR ADDRESS Henry W. Otto, Washington, Mo.

25. DATE RECD. BY LOCAL REG. FEB 13 1960

26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Henry W. Ot

Signature of Student Embalmer

Licensed Embalmer No. 356

P. O. Address Wachu

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.