

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041085

FILED VS NOV 28 1960

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>60 years</i>		c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>Wyatt Park Nursing Home</i> <i>2705 Lafayette</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>6808 Washington Street</i>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>C.</i> Last <i>Capps</i>				4. DATE OF DEATH Month <i>November</i> Day <i>16</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>March 31, 1872</i>	9. AGE (last birthday) <i>88</i>	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) <i>Meat Packing</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Meat packing plant</i>		11. BIRTHPLACE (City and state or country) <i>Eoka, Iowa</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13a. FATHER'S NAME <i>Proctor Capps</i>			13b. MOTHER'S MAIDEN NAME <i>Unknown</i>		14. NAME OF HUSBAND OR WIFE <i>Audie Capps</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Clarence Capps 20 E. Hyde Park Ave.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>						INTERVAL BETWEEN ONSET AND DEATH <i>unk</i>	
DUE TO (b) <i>Arteriosclerotic Heart Disease</i>							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Serile Psychosis</i>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <i>Feb. 1956</i> to <i>Nov. 16, 1960</i> and last saw ^{her} him alive on <i>Nov. 7, 1960</i> Death occurred at <i>11:45 P</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Martin A. Christman</i>			22b. ADDRESS <i>6706 King Hill Ave.</i>			22c. DATE SIGNED <i>Nov. 18, 1960</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Nov. 19, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>		23d. LOCATION (City, town, or county) <i>St. Joseph, Missouri</i>		(State)	
24. FUNERAL DIRECTOR <i>Clark Funeral Home St. Joseph, Mo.</i>			ADDRESS	25. DATE RECD. BY LOCAL REG. <i>Nov. 21, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Handell</i>		

DOCUMENT

M.H. Christman, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____
Signature of Student Embalmer

Signed Earn A. Clark

Licensed Embalmer No. 4238

P. O. Address St. Joseph

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.