

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044550

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 6125

STATE FILE NUMBER

AMENDED

FILED DEC 22 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in 1b 40 Yrs	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 308 So White Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EMMA Middle EVALENA Last CAPPS			4. DATE OF DEATH Month December Day 5 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1888	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St Clair Missouri	12. CITIZEN OF WHAT COUNTRY USA
---------------------------------------------------------------------------------------------------------	-----------------------------------	------------------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME William Nicholas	13b. MOTHER'S MAIDEN NAME Martha Jane Cox	14. NAME OF HUSBAND OR WIFE William Capps
-----------------------------------------------	-----------------------------------------------------	-----------------------------------------------------

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. —	17. INFORMANT Address Arvella Walters 308 So White
-----------------------------------------------------------------------------------------------------------------------	------------------------------	--------------------------------------------------------------

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 DUE TO (b) Coronary Occlusion DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH two days three days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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 June 17, 1963 to Dec. 5, 1961 and last saw her alive on Dec. 5, 1961
Death occurred at 5:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Glenn W. Springer, D.O.	22b. ADDRESS 5902 St. John ave. Kansas City, Mo.	22c. DATE SIGNED 12-6-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/8/1961	23c. NAME OF CEMETERY OR CREMATORY Love Cemetery	23d. LOCATION (City, town, or county) (State) Collins Missouri

24. FUNERAL DIRECTOR Sheil Funeral Home K C Mo.	25. DATE RECD. BY LOCAL REG. 12-6-61	26. REGISTRAR'S SIGNATURE Ruth Long
-----------------------------------------------------------	------------------------------------------------	-----------------------------------------------

DOCUMENT

BY AFFIDAVIT OF Glenn W. Springer, M.D. MEDICAL CERTIFICATION

DATE AMENDED

INSTEAD OF

SIGNATURE SHOULD READ

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 Thomas A. Smith

Licensed Embalmer No. 4954

P. O. Address J. C. 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.