

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-033182

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2277

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 20 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St. Louis		a. STATE Mo.	b. COUNTY - - -
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lemay, Missouri		c. CITY OR TOWN St. Louis	
Length of stay in 1b 18 months		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lemay Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2014 Geyer
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First Erhardt	Middle (n.m.i.)	Last Kapp	Month August	Day 6, Year 1962
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-6-1870	9. AGE (last birthday) 92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Coal	11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY U.S.A. (Nat.)
13a. FATHER'S NAME Hugo Kapp		13b. MOTHER'S MAIDEN NAME Anna Herbstreit		14. NAME OF HUSBAND OR WIFE Bertha F. Kapp (Dec.)
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. none	17. INFORMANT Address Mr. Fred Kapp 6440 Sutherland	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 1 day
IMMEDIATE CAUSE (a) Bronchial Pneumonia		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) _____		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis		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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 Jan. 11, 1960 to Aug. 6, 1962 and last saw ^{her} him alive on Aug. 5, 1962 Death occurred at 10:40 am on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert D. Sanders, M.D.		22b. ADDRESS 1502 Cass Av	22c. DATE SIGNED 8-6-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-9-62	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY	ADDRESS 6464 Chippewa	25. DATE RECD. BY LOCAL REG. SAM 8-6-62	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.
--	---------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

VS 300
Rev. 4/59

14000
2 212

3

4 0

5 2

6

7 2

8 2

9491X

10

11

12 86-c

13

88

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Dr. R. Sanders
1502 Cass
CE. 1-9316

185

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 *Dice C. Brannon*

Licensed Embalmer No. 7764

P. O. Address St. Louis 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.