WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Henry

Township: Leesville

or Village: —

or City: — (NO. ______ St.; ______ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 1117 File No. 39090

Primary Registration District No. 55018 Registered No. 18

FULL NAME Elbert C. Capp

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: 12 (Month) / 1 (Day), 1915 (Year)

AGE: 7 yrs. — mos. 21 ds. If LESS than 1 day, ______ hrs. or — min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Henry Co Mo

PARENTS

NAME OF FATHER: A. J. Capp

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ozark Co Mo

MAIDEN NAME OF MOTHER: Julia A. Little

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tipton Ind

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed. C. Pellor

(ADDRESS) Clinton Mo

Filed 12/24 1912 Ed. C. Pellor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 12 (Month) / 22 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from 12/17, 1912, to 12/22, 1912, that I last saw him alive on 12/22, 1912, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
(I could get no definite information as to exact length of time)

(Duration) — yrs. — mos. 8 ds.

Contributory (SECONDARY) Scarlet fever

(Duration) — yrs. — mos. 10 ds.

(Signed) Ed. C. Pellor M. D.

12/24, 1912 (Address) Clinton Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ______ yrs. ______ mos. ______ ds. In the State ______ yrs. — mos. ______ ds.

Where was disease contracted if not at place of death? —

Former or usual residence ______

PLACE OF BURIAL OR REMOVAL: Parks Chapel

DATE OF BURIAL: 12/23 1912

UNDERTAKER: H. H. Parks

ADDRESS: Clinton Mo. P.O.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.: _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) *1*____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, *191*____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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