

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

Do not use this space.

635

File No. _____
Registered No. 5
St. _____ Ward _____

1. PLACE OF DEATH
 33 County Dent Registration District No. 266
 Township Franklin Primary Registration District No. 5873
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME William Breckridge Cape
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Etta Vise

6. DATE OF BIRTH (MONTH, DAY AND YEAR) -- Oct 14 1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
69 3 5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Jefferson Co
 (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Joel Cape

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Ky 2

12. MAIDEN NAME OF MOTHER Nancy Breckenridge

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) 31

14. INFORMANT Lee Cape
 (Address) Salem Mo

15. FILED 1/20 1932 W.E. Ridd REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/19 1932

17. I HEREBY CERTIFY, that I attended deceased from _____ 19____, and that I last saw him _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis
15 (duration) 15 yrs. mos. ds.
10 (duration) 15 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Arteriosclerosis & Nephritis
 (duration) 15 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Usual Physical
 (Signed) W.E. Ridd, M.D.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Salem, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Miner Cem. DATE OF BURIAL 1/20 1932

20. UNDERTAKER Carl K Spencer ADDRESS Salem Mo

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.

FEB 23 1932

