

REC'D SEP 12 1938

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

26994
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City **St. Louis, Mo.** (d) Street No. **City Hospital** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Samuel Capstick** **123**

(a) Residence, No. **5800 Arsenal** St. **13** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 27 1851.		
7. AGE YEARS 87	MONTHS 6	DAYS 10
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer.		If LESS than 1 day, hrs. or min.
9. Industry or business in which work was done, as saw mill, bank, etc. Retired.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.		
FATHER	13. NAME Samuel Capstick.	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England.	
MOTHER	15. MAIDEN NAME Ellen Aubuchon.	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Florissant Mo.	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **8/6-38-38**

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h..... alive on..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:
Fracture of right hip suffered while slipping and falling the floor at the City Pharmacy on June 14, 1938 at about 3:30 p.m. after a seizure.

Other contributory causes of importance:
Arteriosclerosis

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **Accident** Date of injury **June 14, 1938**
Where did injury occur? **St. Louis** (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. **Public Place**

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **no**
If so, specify.....
(Signed) **Walter G. Perry** M. D.
(Address) **Deputy Coroner**

17. INFORMANT (ADDRESS) **Rose Marshall.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **385 Boston Ave. Florissant Mo.** DATE **Aug. 9, 1938**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **J. J. Quinn. 1389 Union Bl'vd.**

20. FILED **AUG 8, 1938** **J. F. Bredrup** Local Registrar.

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.

FORM 1-12-38
I 114028

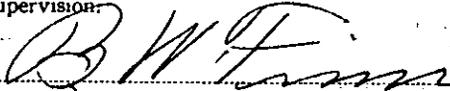
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....



Licensed Embalmer No.....

1591

P. O. Address.....

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 this body is not embalmed, above space should be left blank.