

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.

1939  
9/6  
7  
2

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

23267  
Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 784  
 (b) Township Jefferson Primary Registration District No. 111  
 (c) City Richmond Heights (d) Street No. St. Mary's 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Leon L. Caple  
 (a) Residence, No. 5463 Delmar Blvd. St.  St. Louis  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Florence

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1905-6-23

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>34</u>	<u>-</u>	<u>9</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salesman  
 9. Industry or business in which work was done, as saw mill, bank, etc. Diamond Match Co.  
 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) Durant, Okla.

FATHER  
 13. NAME Elbert Julian Caple  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield, Mo.

MOTHER  
 15. MAIDEN NAME Mattie Pearl Banks  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Durant, Okla.

17. INFORMANT (ADDRESS) Florence Caple, 5463 Delmar Blvd.

18. BURIAL, CREMATION, OR REMOVAL PLACE Durant, Okla. DATE 7/4/39 19.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robert J. Ambruster, Clayton Rd. at Concordia Lane

20. FILED 7/4/39 3 1939 R Meyer MD DPH Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
 I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 12:30 A.  
 The principal cause of death and related causes of importance were as follows:  
Aneurism of the aorta Ruptured

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in 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) John O. Conwell MD M. D.  
 (Address) Coroner, St. Louis County, 10300 Lookland Rd.

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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.....1994

P. O. Address St. Louis.

**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.**