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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36266

Registration District No. 773 Primary Registration District No. 6018A Registrar's No. 180

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town ~~Near Farmington~~ (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 4 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 yr. 6 mo. 4 da. (Specify whether years, months or days)

In this community 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

(c) City or town Elk Township (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Frank Capps

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary Capps

6. (c) Age of husband or wife if alive Age Un years

7. Birth date of deceased May (Month) 9 (Day) 1900 (Year)

8. AGE: Years 39 40 Months 3 Days 25 29 If less than one day hr. min.

9. Birthplace Lyons Co. (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John Capps

13. Birthplace Eddyville (City, town, or county) Kentucky (State or foreign country)

MOTHER 14. Maiden name Unknown

15. Birthplace Dyersburgh (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Records of State Hospt. #4

(b) Address Farmington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-40 (Month) (Day) (Year)

(c) Place: burial or cremation Cem. of State Hospt. #4

18. (a) Signature of funeral director Hugo Cozean.

(b) Address Farmington, Mo.

19. (a) Oct 15-1940 (Date received local registrar) (b) T. S. Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 8 year 1940 hour 5 minute 55 A. M.

21. I hereby certify that I attended the deceased from 5-3, 1940, to 9-8, 1940; that I last saw him alive on 9-7-40, 19; and that death occurred on the date and hour stated above.

Immediate cause of death General Paralysis of Insane (Syphilis) — Duration 5+ yrs

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations No

Of autopsy No

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Geo. Tivis Graves, Jr. (M. D. or other) M. D.

Address Farmington, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Not embalmed

Licensed Embalmer No._____

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.