

DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19231

Registration District No. 8195 Primary Registration District No. 6143 Registrar's No.

1. PLACE OF DEATH:
(a) County: Texas
(b) City or town: Rural
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community 50 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: TEXAS 107
(c) City or town: RURAL (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: JOHN W. CAPE
(b) If veteran, name war
(c) Social Security, No. None

20. DATE OF DEATH: Month MAY day 20
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: ERNEST CAPE
6. (c) Age of husband or wife if alive, years
7. Birth date of deceased: APRIL 1876 (Month) (Day) (Year)

Immediate cause of death: Myocardial Infarction

8. AGE: Years 65 Months 1 Days 11 If less than one day hr. min.

Due to: 4219
Other conditions: (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

9. Birthplace: MISSOURI (City, town, or county) (State or foreign country)

10. Usual occupation: FARMER

11. Industry or business

MOTHER FATHER { 12. Name: ALEXANDER CAPE
13. Birthplace: UNKNOWN (City, town, or county) (State or foreign country)
14. Maiden name: FLORENCE HAYLER
15. Birthplace: UNKNOWN (City, town, or county) (State or foreign country)

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?
While at work? (Specify type of place) (e) Means of injury

16. (a) Informant: Mrs. J. W. Cape
(b) Address: Oregon Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: MAY 23/41 (Month) (Day) (Year)
(c) Place: burial or cremation: NEAR HOME CEMETERY

18. (a) Signature of funeral director: [Signature]
(b) Address: Cabot

19. (a) Date received local registrar: June 4, 1941 (b) Mrs. Julia Lee (Registrar's signature)

23. Signature: [Signature] (M. D. or other)
Address: Houston Mo Date signed: 5/21/41

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

RECEIVED

District Health Officer NO. 5.

District File Number 691175-2

Date Filed _____

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 Gaylad Elliott

Licensed Embalmer No. 2252

P. O. Address Cabell Mo

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.