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23139

1941
SEP 20 1941

Registration District No. 266

Primary Registration District No. 5373

Registrar's No. 48

1. PLACE OF DEATH:
 (a) County Dent
 (b) City or town Rural Franklin typ
(If outside city or town limits, write "RURAL" and name of township)
 (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 X
(Specify whether years, months or days)
 In this community most of his life

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Dent
 (c) City or town Rural Franklin typ
(If outside city or town limits, write "RURAL")
 (d) Street No. X
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? X years.

3. (a) PRINT FULL NAME John A Capps

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Mar 29 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 4 10 hr. min.

9. Birthplace Texas County mo
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business X

12. Name E. F Capps

13. Birthplace Tenn. 1
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann ? apps

15. Birthplace Tenn 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs B. C. Hawkins

(b) Address anutt Mo

17. (a) Burial (b) Date thereof 8/10/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Amitt sm

18. (a) Signature of funeral director [Signature]

(b) Address Salem Mo

19. (a) 8-14-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 9
year 1941 hour 3 minute 45 AM

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Progeria of old age

Due to _____

Due to _____

Other conditions: 162 B

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? [Signature] (Specify type of place) _____
Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]

Address Rolla Missouri Date signed _____

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

MOTHER FATHER

[Signature]
[Signature]
[Signature]

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 8811953

Date Filed

SEP 27 1949

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. 3806

P. O. Address..... Salem, N.J.

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, fact should be so stated above.