

FORM-2-43  
v. 5-17-39  
X35697

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED OCT 15 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 33449

Registration District No. 392

Primary Registration District No. 6153

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Meru Pike  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 5 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

(c) City or town Meru 103  
(If outside city or town limits, write "RURAL")

(d) Street No. near Advance, Mo. 0  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARTIN WILLIAM KAPPLER

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 22  
year 1947 hour 7 minute 50 P.M.

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased February 26 1859  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 19 1947, to Aug 22 1947;  
that I last saw him alive on Aug 22 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years 88 Months 5 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Acute Bronchial Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace New Orleans Louisiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 107

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Jacob Kappler 4

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

14. Maiden name Anna Mary Trapp

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Emma Trapp

(b) Address Advance, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24 1947  
(Month) (Day) (Year)

(c) Place: burial or cremation Crown Cemetery

18. (a) Signature of funeral director Clayton S. Morgan

(b) Address Advance, Mo.

19. (a) Oct. 7 1947 (Date received local registrar) (b) E. C. Straup (Registrar's signature)

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 2

23. Signature E. C. Madris (M. D. or other) Co.  
Address Advance, Mo. Date signed 9.3.47

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

RECEIVED

District Health Office No. 2,

District File Number 1047-1241

Date Filed 10-14-47

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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.....

Lloyd S. Morgan Jr., Registered Apprentice No. 430  
working under my personal supervision.

Signed Lloyd S. Morgan

Licensed Embalmer No. 3361

P. O. Address Advance 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, fact should be so stated above.