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

Do not use this space.

25572

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 1003

Township ..... Primary Registration District No. ..... Registered No. 7165

City St. Louis (No. City Hospital St. ..... Ward)

2. FULL NAME 5923 Frances Rapps

(a) Residence. No. 6 Sidney St. 23 Ward. (Usual place of abode) ..... (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 3 1924

7. AGE: Years 3 | Months 3 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER: Nick Rapps
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Jane Reeves
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Illinois (STATE OR COUNTRY)

14. INFORMANT Hospital Information
(Address) City Hospital

15. FILED AUG -8 1927, 19 ..... Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 7 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927 to Aug 7, 1927 that I last saw her alive on Aug 7, 1927, and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain abscess of frontal lobe of left cerebrum.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Due to Staphylococcus cause unknown (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 70 A

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Johnson Toth, M.D.

8/8, 1927 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: New St. Marcus | DATE OF BURIAL: Aug. 9 1927

20. UNDERTAKER: Wacker-Helderle | ADDRESS: 2331 So. Bing

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.

Kappa,