

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

Do not use this space.

26349

1. PLACE OF DEATH

County Franklin
Township Union
City Union

Registration District No. 296
Primary Registration District No. 4180

File No. 16
Registered No. _____
St. _____ Ward _____

2. FULL NAME Marie Elizabeth Raps

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 84 yrs. 3 mos. 0 da. How long in U.S., if of foreign birth? yrs. _____ mos. _____ da. _____
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 7th 1846
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
84 3 0

8. OCCUPATION OF DECEASED Retired Housekeeper
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Union, Missouri.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Albert Lindner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Marie Kline
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY) _____

14. INFORMANT Mrs. Henry Heeger
(Address) Union, Mo.

15. FILED Aug 8, 1930 E. J. Stenhouse
REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 7 1930
17. I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to Aug 7, 1930 that I last saw her alive on Aug 7, 1930 and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile Dementia

CONTRIBUTORY (SECONDARY) Fracture of Femur
(duration) _____ yrs. _____ mos. _____ da.
(duration) 1 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: See Home

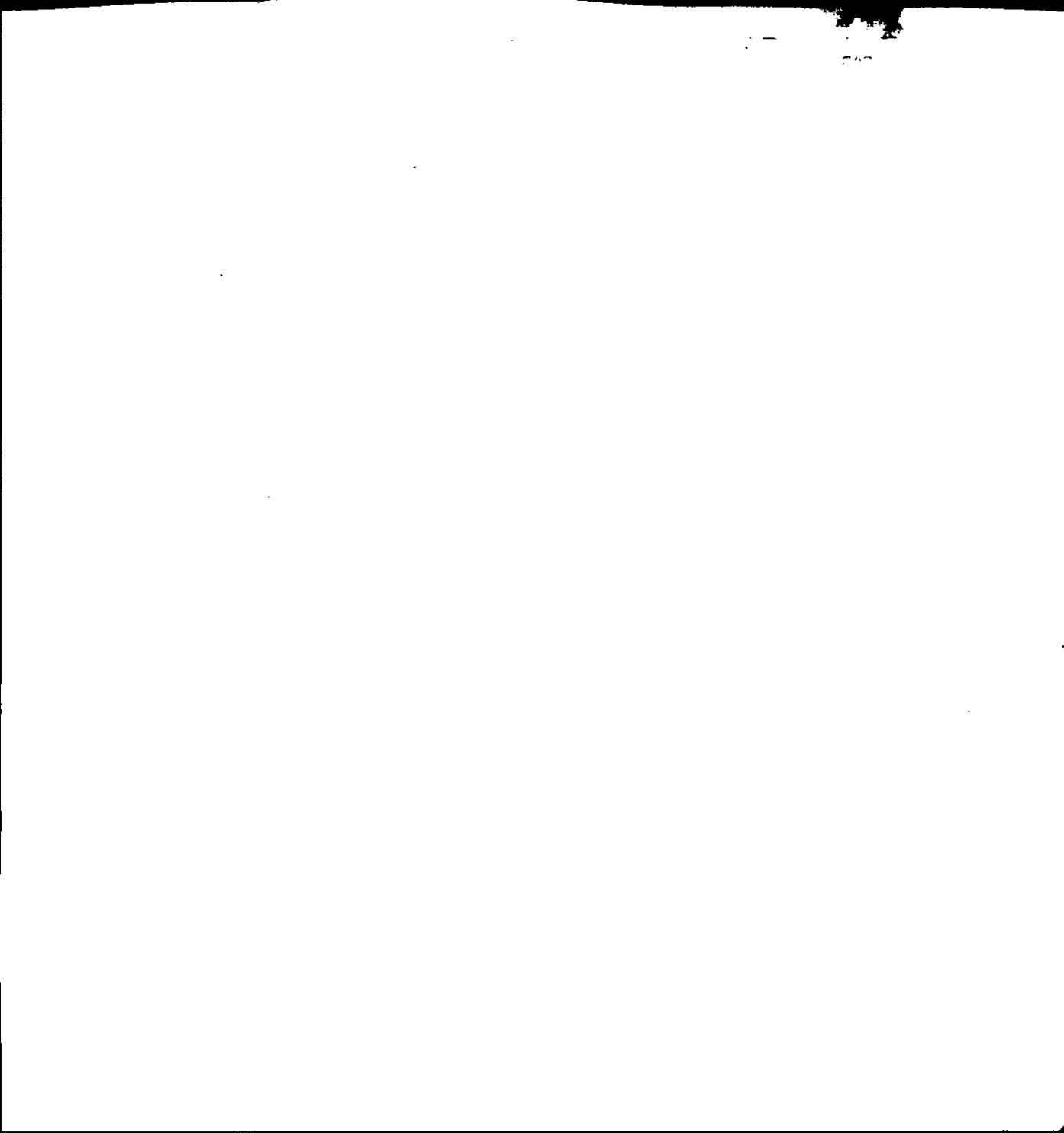
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAM TEST CONFIRMED DIAGNOSIS: Senile Dementia
(Signed) E. J. Stenhouse, M. D.
Aug 8, 1930 (Address) Union Mo

*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 Union Cemetery
Union, Mo. DATE OF BURIAL Aug 9 1930

20. UNDERTAKER Union Furniture ADDRESS Union, Mo.
By Wm. H. Horn



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Franklin Registration District No. 296 File No.
 Township Primary Registration District No. 4180 Registered No.
 City Union (No) St. Ward)

2. FULL NAME

Marie Elizabeth Rapp
 (a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED Aug 8, 1920 E.A. Stinburg REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 7 19 20

17. I HEREBY CERTIFY That I attended deceased from
 that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) Fracture of femur (duration) yrs. mos. ds.
Fell on floor at side of bed (duration) yrs. mos. ds.
at his home in his bedroom

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) 185 M. D

, 19 (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRATION FEE F. CERTIFICATES UNTIL 1917 ARE COMPLETE DESCRIBED BY LAW

SUPPLEMENTARY

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