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

Do not use this space.

11979

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 10083

City ST. LOUIS MO. (No. DE PAUL HOSPITAL. St. ..... Ward)

File No.....

Registered No. 3228

2. FULL NAME LOUIS H. RAUP.

(a) Residence. No. FLORISSANT MO. St., 6 Ward. Florissant Mo
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
MALE.	WHITE.	WIDOWER.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5/16/1871.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	59	9	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work GARDENER.

(b) General nature of industry, business, or establishment in which employed (or employer) SELF.

(c) Name of employer

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

PARENTS

10. NAME OF FATHER JOSIAH RAUP.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) NOT KNOWN.

12. MAIDEN NAME OF MOTHER NOT KNOWN.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) NOT KNOWN.

14. INFORMANT Victor Raup.
(Address) Florissant Mo.

15. FILED ..... 19 ..... Mary C Vandergriff
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/11/31. 19 31

17. I HEREBY CERTIFY, That I attended deceased from 3/9/31, 19 31, to 3/11/31, 19 31, that I last saw him alive on 3/11, 19 31, and that death occurred, on the date stated above, at 12-30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Edema of Lungs
Myocarditis
Chronic Myocarditis (duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? At Home

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) L. M. Riggan, M. D
3/12, 19 31 (Address) Lisbon Bldg

*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
MEMORIAL PARK.	3/14/31 19

20. UNDERTAKER Provost Lund Co ADDRESS 3710 N. Grand

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.