

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.

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

Do not use this space.

42219

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1002**  
City **St. Louis, Mo.** (No. **DePaul Hospital**)..... St. .... Ward)

File No. ....  
Registered No. **84**.....  
St. .... Ward)

**2. FULL NAME**

**Clara Charlotte Rapp**

(a) Residence, No. **5445 Nebraska** St. **15** Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred **0** Yrs. .... mos. .... ds. How long in U. S., if of foreign birth? yrs. .... mos. .... ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Female</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Widowed</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Frank Aldt Rapp</b>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>Jan 21 1863</b>		
7. AGE	YEARS	MONTHS
	<b>80</b>	<b>11</b>
		<b>10</b>
		If LESS than 1 day, .... hrs. .... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <b>Housewife</b>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year).....	
	11. Total time (years) spent in this occupation.....	

**2 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Dec 31 1923**

22. I HEREBY CERTIFY, That I attended deceased from **Dec 28 1923** to **Dec 31 1923**

I last saw her alive on **Dec 31 1923**. Death is said to have occurred on the date stated above, at **7:25 A. M.**

The principal cause of death and related causes of importance were as follows:

**Lobar pneumonia**  
**108**  
**112**  
**106**  
Other contributory causes of importance:  
**Bronchial asthma**  
**1923**

Date of onset  
**12/28**

12. BIRTHPLACE (CITY OR TOWN) **Stannan, Mo.**  
(STATE OR COUNTRY)

13. NAME **Michaelis**

14. BIRTHPLACE (CITY OR TOWN) **Not known**  
(STATE OR COUNTRY)

15. MAIDEN NAME **Not known**

16. BIRTHPLACE (CITY OR TOWN) **Not known**  
(STATE OR COUNTRY)

17. INFORMANT **Oliver Rapp**  
(ADDRESS) **5445 Nebraska St**

18. BURIAL, CREMATION, OR REMOVAL  
PLACE **Memorial Park** DATE **Jan 3rd 1924**

19. UNDERTAKER **Kennelchuss Memorial Co**  
(ADDRESS) **3402 St. Louis Highway**

20. FILED **At 11:49**  
**J. B. Brubaker**  
Registrar.

Name of operation **None** Date of **None**  
What test confirmed diagnosis? **None** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify **None**  
(Signed) **Memmet Lane** , M. D.  
(Address) **1117 N Grand**

