

REC'D MAR 9 1939

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

5882
Do not use this space.

1. PLACE OF DEATH *Boone* 2
(a) County *Boone* Registration District No. *78*
(b) Township Primary Registration District No. *404p* Registered No. *3*
(c) City *Rochport* (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Sallie RAPP*
(a) Residence, No. *Rochport Mo* St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 2 1868*
7. AGE YEARS *72* MONTHS *X* DAYS *13* If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. *Housewife*
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 15 1939*
I HEREBY CERTIFY, That I attended deceased from *Feb 11 - 1938*, to *Jan 15 - 1939*
I last saw h. *u* alive on *Jan 15 - 1939*. Death is said to have occurred on the date stated above, at *4 P.* m.
The principal cause of death and related causes of importance were as follows:
Pulmonary Tuberculosis Date of onset *Don't know*
Began about Feb 1938
Other contributory causes of importance: *73'*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Howard Co Mo*
13. NAME *EVEN EVANS* 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know* 9
15. MAIDEN NAME *Catherine E ONeil*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*
17. INFORMANT *George RAPP* (ADDRESS) *Rochport mo*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Rochport* CEMETERY DATE *Jan 17th 1939*
19. FUNERAL DIRECTOR (ADDRESS) *R. Owens*
20. FILED *2-14-39* *Mary P. Singell* 77 (Address) *Rochport Mo*

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
(Signed) *H. E. Singell*, M. D.
(Address) *Rochport Mo*

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.

STATEMENT BY LICENSED EMBALMER

I, R. O. Willcott, Licensed Embalmer No. 3183

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Arterial & Cavity

L. E.

No. _____ or by _____, Registered Apprentice No. 3183

working under my personal supervision.

Signed R. O. Willcott

Licensed Embalmer No. 3183

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.)