

Registration District No. **791** Primary Registration District No. _____

1. PLACE OF DEATH: **1000**
(a) County _____ **NOV 13 1939**
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County _____
(c) City or town West Frankfort **NR**
(If outside city or town limits, write "RURAL")
(d) Street No. 410 West St. Louis
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

In this community _____ years, months or days
3. (a) PRINT FULL NAME Russell Stewart Delap
3. (b) If veteran, name war _____ 3. (c) Social Security No. 361-05-702
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Sarah 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 20 - 1886
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 23 year 1939 hour 9 minute 0'clock A.M.
21. I hereby certify that I attended the deceased from October 20, 1939 to October 23, 1939; that I last saw him alive on October 23, 1939; and that death occurred on the date and hour stated above.
Immediate cause of death Pneumonia Duration 3 days

8. AGE: Years 52 Months 11 Days 3 If less than one day _____ hr. _____ min.
9. Birthplace White County, Illinois
(City, town, or county) (State or foreign country)

Due to Ruptured splenic abscess
Due to Septicemia from lung abscess bmo.
Other conditions liver abscesses
(Include pregnancy within 5 months of death)

10. Usual occupation Carpenter
11. Industry or business _____
MOTHER FATHER { 12. Name Darius Delap
18. Birthplace White County, Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Zook
15. Birthplace White County, Illinois
(City, town, or county) (State or foreign country)

Major findings: non tubercular
Of operations _____
Of autopsy 73a
PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Ralph Delap
(b) Address 2652 Russell
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/24/39
(Month) (Day) (Year)
(c) Place: burial or cremation West Frankfort, Ill.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

19. (a) Oct 24 1939 (Date received by Registrar) (b) _____ (Registrar's signature)

28. Signature H. P. Bierman (M. D. or other) _____
Address BARNES HOSPITAL Date signed _____

MARGIN RESERVED FOR BINDING
 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

FORM 5-17-39
 REV. 6-17-39
 U. S. GOVERNMENT PRINTING OFFICE: 1938

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Gray W. Welbenson*

Licensed Embalmer No..... *3575*

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.