

S. No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30755**
8512
Registrar's No.

Registration District No. **299**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2843 Troost
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 days**
(Specify whether
In this community **3 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clay**
(c) City or town **North Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **330 E. 24th**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Margaret Rapp
3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **female** / 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Geo. M. Rapp** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **February 17, 1862**
(Month) (Day) (Year)

8. AGE: Years **79** Months **7** Days **12**
If less than one day
hr. min.

9. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER { 12. Name **unknown**
13. Birthplace **9**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Marvin Rapp**
(b) Address **830 E. 24. North K. C. Mo.**
17. (a) **removal** (b) Date thereof **9-22-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Ht. Jora St. Joseph Mo.**

18. (a) Signature of funeral director **Morton Funeral Home**
(b) Address **North Kansas City, Missouri**

19. (a) **9/21/1941** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **19**
year **1941** hour **5** minute **45** M.
21. I hereby certify that I attended the deceased from **Sept. 15th**
1941 to **Sept. 19** **1941**
that I last saw him alive on **Sept. 19** **1941**
and that death occurred on the date and hour stated above.
Immediate cause of death **Oedema of lungs** Duration **4 days**

Due to **Parkinsons disease**

Due to **Arterio Sclerosis**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations **None**
Of autopsy **None**

PHYSICIAN
Underline the cause to which death should be charged statistically.

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?

(Specify type of place) While at work? (c) Means of injury
23. Signature **James J. Flynn** (M. D. or other) **M.D.**
Address **2220 4th St. N.** Date signed **9/20/41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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Dr. Flynn.
31st & Brooklyn.

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.....

.....**Harold L. Posson**....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Harold L. Posson

Licensed Embalmer No. 3605

P. O. Address **North K. C. Mo.**

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, fact should be so stated above.