

FILED MAY 21 1942

Registration District No.

Primary Registration District No. 4465-

Registrar's No. 15

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

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Flat River, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 94
(c) City or town _____ (If outside city or town limits, write "RURAL") 5
(d) Street No. _____ (If rural, give location) 2
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Lillie Rapp

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased April 6 1851
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>91</u>	<u>0</u>	<u>10</u>	hr. _____ min. _____

9. Birthplace don't no 1 Pennsylvania
(City, town, or county) (State or foreign country)

10. Usual occupation Care of home

11. Industry or business _____

MOTHER FATHER

12. Name William Reel

13. Birthplace don't no 1 Pennsylvania
(City, town, or county) (State or foreign country)

14. Maiden name Kristencl Clabough

15. Birthplace don't no 1 Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Rapp

(b) Address Flat River Missouri

17. (a) Burial (b) Date thereof Apr. 15, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francois

18. (a) Signature of funeral director C. J. Boyle

(b) Address Dealoge Missouri

19. (a) 4-18-42 (b) Byrdie S. Bukhmetov
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16 year 1942 hour 6:30 minute 0 M.

21. I hereby certify that I attended the deceased from 4/17/42 to 4/16, 1942

that I last saw her alive on 4/15/42, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Chc myeloiditis
Senility

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) _____ (Means of injury)

23. Signature C. H. [unclear] (M. D. or other) MD
Address Flat River Mo. Date signed 4/15/42

RECEIVED

District Health Officer No. 4

District File Number 542-565

Date Filed 5-12-42

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 C. J. Boyer
Licensed Embalmer No. 1671
P. O. Address Desloge 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.