

FILED JUL 6 1947 '91

Registration District No.

Primary Registration District No.

1003

Registrar's No.

5412

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4841 Germania Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
Life (Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4841 Germania Ave.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Anna A. Drapp

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, Single

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased September 10 1867
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 11 If less than one day hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business.....

12. Name John Drapp

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Mary Brown

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Deck
(b) Address 3403a Utah St.

17. (a) Burial (b) Date thereof 6/25/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Wacker Aldrich & Co.

(b) Address 3634 Gravois Ave.

19. (a) HN 74 (b) J. F. Busch
(Date of local health district) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21 st. year 1942 hour 9:00 minute P. M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw him..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis; Arterio Sclerosis.

Due to.....

Due to.....

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

Major findings: Of operations.....

Of autopsy.....

Duration

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 Thomas F. Callanan M.D. or other.....

Address Deputy Coroner Date signed 6/24/42

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

MOTHER, FATHER

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.....

Frank J. Ryland

Licensed Embalmer No.....

9645

P. O. Address.....

St. Louis, 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.

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