. S. No. 2
I—11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 670

FILED JAN 19 1943 318

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 168

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:
City Hospital #1. 0
(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: 000 17 9 5

(a) State Mo. (b) County .....

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1045 Hodiamont Ave.,
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Dr. Fred B. Rapp.

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race 0 White

6. (a) Single, widowed, married, divorced 0 Single

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Feb. 9, 1877.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	10	28	..... hr. ..... min.

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

10. Usual occupation Dentist.

11. Industry or business .....

FATHER
12. Name ? Rapp.
13. Birthplace Connecticut
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Callie Burnell
15. Birthplace Connecticut
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jessie Hooper
(b) Address 1045 Hodiamont Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8/43.
(Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.,

18. (a) Signature of funeral director Jos. W. Clark,
(b) Address 1125 Hodiamont Ave.,

19. (a) JAN 7 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 6
year 1943 hour 2:25 minute A.M. M.

21. I hereby certify that I attended the deceased from ..... , 19..., to ..... , 19...;
that I last saw h..... alive on ..... , 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis due to Ruptured Gastric Ulcer

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

23. Signature Alfred J. Perry (M. D. or other)
Address Dept of Com Date signed 1/8/42

(Licensed Embalmer's Statement on Reverse Side)

City Coroner

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.....

Licensed Embalmer No. 5285

P. O. Address 1125 Hodiamont Ave.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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