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DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

9188

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital, Max C. Starkloff
(If not in hospital or institution, write street number or location) **Memorial**
(d) Length of stay: In hospital or institution **4 Days**
(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** **17**
(If outside city or town limits, write "RURAL") **912**
(d) Street No. **5153 ENRIGHT ST.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ **0**

3. (a) PRINT FULL NAME **Clara Reppy**

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, widowy **2 divorced WIDOWY**
6. (b) Name of husband or wife **John Reppy** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **1 SEPT. 26 1865**
(Month) (Day) (Year)

8. AGE: Years **78** Months **0** Days **17** If less than one day _____ hr. _____ min.

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

10. Usual occupation **NIL**

11. Industry or business

MOTHER { 12. Name **JESSIE JONES**
13. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)
14. Maiden name **FRANCES TODD**
15. Birthplace **KENTUCKY**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Jessie C. Renfrow**
(b) Address **5153 Enright**
17. (a) **BURIAL** (b) Date thereof **Oct. 15-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CAMEL CEM FESTUS MO**
18. (a) Signature of funeral director **E. J. Schurmer**
(b) Address **3125 Lafayette Av.**
19. (a) **OCT 19 1943** (b) **J. P. Medear**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **13**,
year **1943** hour **8:40** minute **A.** M.

21. I hereby certify that I attended the deceased from **October 10**, 19 **43** to **October 13**, 19 **43**
that I last saw him **alive** on **October 13**, 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic Heart Disease**

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy **None**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **None**
(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 _____

23. Signature **William J. Darr** (M. D. or other) **10/13/43**
Address **1515 Lafayette Avenue** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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 Joe B. Vollmer

Licensed Embalmer No. 41014

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.