

FILED JAN 6 1944

Registration District No. **1524** Primary Registration District No. **3017**

1. PLACE OF DEATH:  
(a) County **Cooper**  
(b) City or town **Boonville**  
(c) Name of hospital or institution:  
**1101 Sixth St.**  
(d) Length of stay: In hospital or institution **----**  
In this community **All of life.**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Cooper**  
(c) City or town **Pilot Grove, Mo.**  
(d) Street No. **Rural**  
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Mrs. Neoma Sophia Gilson Rapp**

3. (b) If veteran, name war **----** 3. (c) Social Security No. **----**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Fred Rapp.** 6. (c) Age of husband or wife if alive **58** years  
7. Birth date of deceased **July 23<sup>rd</sup> 1893**

8. AGE: Years **51-** Months **54** Days **4** 19 **31** hr. **19** min.

9. Birthplace **Boonville, Missouri**

10. Usual occupation **Housewife.**

11. Industry or business **At Home**

MOTHER FATHER { 12. Name **Ben Gilson.**  
13. Birthplace **Missouri**  
14. Maiden name **Elizabeth Cobhran.**  
15. Birthplace **Missouri.**

16. (a) Informant **Fred Rapp.**  
(b) Address **Pilot Grove, Mo.**

17. (a) **Burial** (b) Date thereof **Dec. 14<sup>th</sup> 1943**

(c) Place: burial or cremation **Walnut Grove Cem.**

18. (a) Signature of funeral director **Goodman & Boller**  
(b) Address **Boonville, Mo.**

19. (a) **Dec 14-43** (b) **Dr. Chas. Swap.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **12**  
year **1943** hour **8** minute **45 p.m.**

21. I hereby certify that I attended the deceased from **1940**, 19 **to death.**, 19 **1943**  
that I last saw her alive on **12-10**, 19 **1943**  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Cerebral accident.**  
**Carcinoma of cervix**  
**Due to Chronic valvular heart disease**

Due to **Other conditions:**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations **HSA**  
Of autopsy

Duration  
**2 days**  
**1 year**  
**year**

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) (e) While at work? (f) Means of injury: **(C)**  
23. Signatur **Geo. W. Blankenship M.D.** (M. D. or other) **----**  
Address **Boonville, Mo.** Date signed **12-13-43**

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

1088

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-5-42 \_\_\_\_\_

---

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 G. F. Roller  
Licensed Embalmer No. 3062  
P. O. Address Boonville, 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.**