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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35763

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10337

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: Booth Memorial Hospital
(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 Missouri (b) County → 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3707 Olive 19
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No) 0
If yes, name country —

3. (a) PRINT FULL NAME Glenn Elwood Rapert
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male 0
5. Color or race W
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased 10 (Month) — 30 (Day) — 45 (Year)
8. AGE: Years | Months | Days | If less than one day 8 hr. 11 min.
9. Birthplace St Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation —
11. Industry or business —
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Louella Dean Rapert
15. Birthplace Middlebrook, Arkansas (City, town, or county) (State or foreign country)
16. (a) Informant Louella Dean Rapert
(b) Address 3707 Olive
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-45 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY
18. (a) Signature of funeral director V. B. Hudson
(b) Address City Health Dept
19. (a) 11-29-45 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30th year 1945 hour 12 minute 05 P.M.
21. I hereby certify that I attended the deceased from October 30th, 1945, to October 30, 1945, that I last saw him alive on October 30, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Atelectasis - Congenital Hypertrophied Thymus
Due to
Due to Congenital Defects
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy 1) Pulmonary Atelectasis 2) Hypertrophied Thymus

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 William T. Hyatt M.D. (M.D. or other)
Address 508 No. Grand Ave (3) Date signed 11/1/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....

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.