

S. No. 2
M-5-43
5-17-39
I X36671

FILED JUN 26 1946
Registration District No. **318**

Primary Registration District No. **1003**

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:
Park Lane Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3511 A. Illinois Ave**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William F. Rippley**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **17th** day **June**
year **1946** hour **5:45** minute **P.** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Katherine Rippley**
6. (c) Age of husband or wife if alive **45** years
7. Birth date of deceased **January 16 1893**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **6*15-46** 19____ to **6-17-46** 19____
that I last saw h. **im** alive on **6*17-46** 19____
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
53 **5** **1** hr. _____ min.

Immediate cause of death _____
General Peritonitis
Due to **Ruptured Appendix.** **2da.**

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)
10. Usual occupation **Insurance Agent**

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

11. Industry or business **Reliable Ins. Co**
12. Name **William Rippley**
13. Birthplace _____
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

14. Maiden name **Catherine Diehl**
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Katherine Rippley**
(b) Address **3511 A. Illinois Av**
17. (a) **Burial** (b) Date thereof **June 20 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews Cemetery**
18. (a) Signature of funeral director **Zeigebauer Bros**
(b) Address **6409 Gravois Ave**

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? _____

19. (a) **JUN 20 1946** (b) _____
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature **J. J. Bredek** (other) _____
Address **4930 Lindell Blvd** Date signed **6/18/46**

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.....

Licensed Embalmer No. 3881

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.