

S. No. 2
-12-45
5-17-39
-1 X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **11429**

FILED MAR 23 1947

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2403**

1. PLACE OF DEATH:
(a) County St. Louis
(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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4130a Ashland Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Julia Rapplean
(b) If veteran, name war _____
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar. day 6
year 1947 hour 4 minute P M.
21. I hereby certify that I attended the deceased from 2/5/47
to 3/6/47
that I last saw her alive on 3/6/47
and that death occurred on the date and hour stated above.

4. Sex Female Color or race White
6. (a) Single, widowed, married, divorced. Widowed
6. (b) Name of husband or wife James Rapplean
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 26 1861
(Month) (Day) (Year)

Immediate cause of death Cerebro-Vascular Hemorrhage Duration 1 1/2 weeks
Due to hypertensive - C-V disease 5 yrs.
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

8. AGE: Years Months Days If less than one day
85 9 10 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name (d) (?) Welch

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name (e) (?) Kerns

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Nellie Rapplean

(b) Address 4130a Ashland Ave.

17. (a) Burial (b) Date thereof 3/10/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge Ave.

19. (a) MAR 8 1947 (b) J. Medeck
(Date received local registrar) (Registrar's signature)

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? _____
While at work? Working for Parker, M.D. (Specify type of work) (e) Means of injury _____
23. Signature 1515 Lafayette (Date signed) 3/8/47
Address _____

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.....

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.