

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

58-016334
STATE FILE NUMBER
4164

FILED APR 23 1958

Registration District No. 318 Primary Registration District No.

Registrar's No.

300
1-57

| | | | | | |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hosp. | | Length of stay in lb | d. STREET ADDRESS 4526 S. Compton | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Valentine V. Rapp | | | First Middle Last | | 4. DATE OF DEATH Month Day Year April 14, 1958 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 5, 1893 | | 9. AGE (In years of birthday) 64 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | |
| 13a. FATHER'S NAME Henry Rapp | | 13b. MOTHER'S MAIDEN NAME Elizabeth Reiss | | 14. NAME OF HUSBAND OR WIFE Esther Rapp | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none | | 16. SOCIAL SECURITY NO. 493-05-7146 | | 17. INFORMANT Address Esther Rapp 4526 S. Compton | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | 331X |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chromidial arterial stenosis | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from Jan 6, 1958 to April 14, 1958 and last saw ^{her} _{him} alive on April 14, 1958 Death occurred at 11:35 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Albert J. Gnade MD | | | 22b. ADDRESS 3606 Grannis | | 22c. DATE SIGNED 4-16-58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 4-17-58 | 23c. NAME OF CEMETERY OR CREMATORY Calvary | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
| 24. FUNERAL DIRECTOR Southern Funeral Home ADDRESS 6322 S. Grand, St. Louis, Mo. | | | 25. DATE RECD. BY LOCAL REG. APR 16 '58 | | 26. REGISTRAR'S SIGNATURE Paul Smith MD |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Dr Inade
3606 Graves
1 to 4

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Samuel Van Fossan*

Licensed Embalmer No. *4342*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.