

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046189

STATE FILE NUMBER 11684

FILED JAN 6 1959

Registration District No. 318

Primary Registration District No. 1003

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 <i>ST. LOUIS</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Pagedale</i>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Jewish Hospital</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>6509 Julian Ave</i>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Elinor</i> Middle <i>F.</i> Last <i>Rapp</i>			4. DATE OF DEATH Month <i>12</i> Day <i>3</i> Year <i>58</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/13/1916</i>	9. AGE (In years past birthday) <i>42</i>	10. FUNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Trimmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>	11. BIRTHPLACE (City and state or country) <i>Pilot Grove Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>

13a. FATHER'S NAME <i>John A. Grotzinger</i>	13b. MOTHER'S MAIDEN NAME <i>Catherine M Nold</i>	14. NAME OF HUSBAND OR WIFE <i>Albert W. Rapp</i>
-------------------------------------------------	------------------------------------------------------	------------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>None</i>	16. SOCIAL SECURITY NO. <i>493-12-0844</i>	17. INFORMANT <i>Albert W. Rapp</i>	Address <i>6509 Julian Ave.</i>
--------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------	----------------------------------------	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>terminal Carcinoma - metastatic</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 mos.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>adeno-carcinoma breast</i>	
	DUE TO (c) <i>170x</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 <i>St. Louis</i>		COUNTY <i>Mo.</i>

21. I attended the deceased from *1957* to *12-2-58* and last saw *live on* *12-2-58*
Death occurred at *424* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Melvin B. Koestel M.D.</i>	22b. ADDRESS <i>950 Francis Pl.</i>	22c. DATE SIGNED <i>12-4-58</i>
-------------------------------------------------------------------	----------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12/6/58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>
------------------------------------------------------------	-----------------------------	---------------------------------------------------------------	-----------------------------------------------------------------------

24. FUNERAL DIRECTOR <i>Jos. W. Clark</i>	ADDRESS <i>1125 Hodiamont</i>	25. DATE RECD. BY LOCAL REG. <i>DEC 4 '58</i>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>
----------------------------------------------	----------------------------------	--------------------------------------------------	---------------------------------------------------------

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

S.P.

Dr. M.B. Kustein
950 Francis Pl.

CI

Pa. 7-1452

10:30 AM 12:30

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 *Alfred J. Boedeker*

Licensed Embalmer No. *2663*

P. O. Address *1125 Hickman*

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.