

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000656

FILED VS JAN 20 1960

Registration District No. 59 Primary Registration District No. _____ Registrar's No. 13

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>PASS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PASS</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DREXEL</u>		Length of stay in 1b <u>18 YRS</u>		c. CITY OR TOWN <u>DREXEL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2ND + MAIN</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CHRIS</u> Middle _____ Last <u>RAPP</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>10.</u> Year <u>1960</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-30-1999</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYMENT DEALER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>EMPLOYMENT</u>		11. BIRTHPLACE (City and state or country) <u>WHEATLAND, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>PHILIP RAPP</u>			13b. MOTHER'S MAIDEN NAME <u>MARGARET MEYER</u>			14. NAME OF HUSBAND OR WIFE <u>SELMA RAPP</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>500-22-2550</u>		17. INFORMANT Address <u>MRS CHRIS RAPP DREXEL, MO</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u> DUE TO (b) <u>Hanging by neck</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Hanged by the neck.</u>							
20c. TIME OF INJURY Hour <u>10:30</u> a.m. Month, Day, Year <u>Jan 10/60</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>office Bldg.</u>		20f. CITY, TOWN, OR LOCATION <u>Drexel, Mo.</u>		COUNTY _____ STATE _____	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>10:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Robert C. Phillips, D.C. coroner</u>				22b. ADDRESS <u>302 S. Independence, Harrisonville, Mo.</u>			22c. DATE SIGNED <u>1/19/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-13-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SHARON CEMETERY</u>		23d. LOCATION (City, town, or county) <u>DREXEL</u>		23e. STATE <u>MISSOURI</u>			
24. FUNERAL DIRECTOR ADDRESS <u>RUNYAN FUNERAL HOME DREXEL, MO</u>			25. DATE RECD. BY LOCAL REG. <u>JAN 12-60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Gay LeBue</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS MAR 24 1961

JAN 26 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by Larry S. Todd Student Embalmer No. 56
working under my personal supervision.

Student Larry S. Todd
Signature of Student Embalmer

Signed David E. White

Licensed Embalmer No. 495

P. O. Address Leitchburg

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.