REC'D AUG 9 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

24981
Do not use this space.

1. PLACE OF DEATH
(a) County Boone
(b) Township or City Columbia
(c) Registration District No. 73
Primary Registration District No. 3006
Registered No. 150
(d) Street No. Noyes Hospl St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

10
3
4

2. PRINT FULL NAME Robert Rapp Jr
(a) Residence, No. Rochport Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): MAR 2 1919
7. AGE: YEARS 20 MONTHS 4 DAYS 16 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Labor Epple Const Co
10. Date deceased last worked at this occupation (month and year) July 17 1939
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rochport Mo

FATHER
13. NAME Robert Rapp
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard Co Mo

MOTHER
15. MAIDEN NAME Mettie M. Brown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard Co Mo

17. INFORMANT (ADDRESS) Robert Rapp Rochport, Mo.
18. BURIAL, ~~CREMATION, OR REMOVAL~~ PLACE Memorial Park DATE July 19th 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) R O Willett Columbia, Mo.
20. FILED 7/19/1939 Allie Selby Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 18 1939
22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 12 55 A m.
The principal cause of death and related causes of importance were as follows:

Compound fractures of skull received from a fall down Elevator At Christian College Building under Construction

Date of onset

Other contributory causes of importance:

2037

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 7/17, 1939
Where did injury occur? COLUMBIA, Mo. (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Building Construction
Manner of injury FALL DOWN ELEVATOR
Nature of injury COMPOUND

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) W. R. Toalson Coroner M.D.
74 (Address) 20 N 9 St.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X16605

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~~ Me

....., Registered Apprentice No.....

working under my personal supervision.

Signed Lyman H. Spaunk

Licensed Embalmer No. 4013

P. O. Address Columbia Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.