

Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Wellston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6160 Gambleton Place /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Nellie M. Apel**
3. (b) If veteran, name war _____ **3. (c) Social Security No.** **No**

4. Sex **Female** / **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **Widow 2**
6. (b) Name of husband or wife **Edward F. Apel** **6. (c) Age of husband or wife if alive** **Dec'd** years
7. Birth date of deceased **September 14th, 1863**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	2	28	hr. _____ min.

9. Birthplace **Union City Mich** /
(City, town, or county) (State or foreign country)
10. Usual occupation **At Home**

11. Industry or business
12. Name **Frank W. Bubb**
13. Birthplace **Harrisburg Penn** /
(City, town, or county) (State or foreign country)
14. Maiden name **Louisa Rappelyea**
15. Birthplace **New York** /
(City, town, or county) (State or foreign country)

16. (a) Informant **W. J. Lonergan**
(b) Address **6160 Gambleton Pl**
17. (a) Burial **(b) Date thereof** **12/14/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Grove**

18. (a) Signature of funeral director **Robert J. Ambruster Inc**
(b) Address **6633 Clayton Road**
19. (a) 12-16-46 **(b) [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis** **96**
(c) City or town **Wellston** **9**
(If outside city or town limits, write "RURAL")
(d) Street No. **6160 Gambleton Pl.** **9**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **12th**
year **1946** hour **3.20** minute **A** M.
21. I hereby certify that I attended the deceased from _____, 19____, to **12/12/46**, 19____;
that I last saw her alive on **12/11/46**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** **Duration 2 wks.**
Due to **830**
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: **NOT**
(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? _____ (Specify type of place)
(a) Means of injury _____
23. Signature **[Signature]** (M. D. or other) **M.D.**
Address **1492 Hodiamont Ave** Date signed **12/13/46**

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 *Arnold W. Schoene*.....

Licensed Embalmer No. *3864*.....

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 this body is not embalmed, fact should be so stated above.