

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6624**  
**1247**  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>St Clair</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St Louis</b>		c. LENGTH OF STAY (in this place) <b>7 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Caseville Twp. R. 1</b>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Louis Children's Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>Caseville Twp. R. 1</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Gary</b>		b. (Middle) <b>Leonard</b>		c. (Last) <b>Rupprecht</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>2 7 49</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>6-28-43</b>		9. AGE (In years last birthday) <b>5</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CHILD</b>		11. BIRTHPLACE (State or foreign country) <b>TACOMA, WASH.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>Leonard O. Rupprecht</b>		13b. MOTHER'S MAIDEN NAME <b>CATHRINE HERBSTREITH</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Leonard Rupprecht Collinsville, Ill.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Brain tumor type undetermined, cerebellum - pontine angle.</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>1937 57</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>1-31</b> , 19 <b>49</b> , to <b>2-7</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>2-7</b> , 19 <b>49</b> , and that death occurred at <b>11:06 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Neal J. Carson M.D.</b>				23b. ADDRESS <b>Collinsville, Ill.</b>		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>2/9/48</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		24d. LOCATION (City, town, or county) (State) <b>Collinsville Ill.</b>		
DATE REC'D BY, LOCAL REG. <b>FEB 9</b>		REGISTRAR'S SIGNATURE <b>J. B. Sarsater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Geo. M. Schaeffler Collinsville, Ill.</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.

Signed .....

*Geo. M. Schaeppel*

Signed .....

Student Embalmer

Licensed Embalmer No. ....

*1598*

P. O. Address .....

*Collinsville, Ill*

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

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