

FILED OCT 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30937

BIRTH NO. _____ REG. DIST. NO. 383 PRIMARY REG. DIST. NO. 5655 Registrar's No. 265

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mt. Vernon		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri State Sanatorium		d. STREET ADDRESS (If rural, give location) 400 So. 5th St.	

3. NAME OF DECEASED (Type or Print) a. (First) Thomas, Sr.	b. (Middle)	c. (Last) Rapp	4. DATE OF DEATH (Month) (Day) (Year) Oct. 8, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 28, 1892	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Benton, Illinois	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Michael J. Rapp	13b. MOTHER'S MAIDEN NAME Laura Moore	14. NAME OF HUSBAND OR WIFE Mrs. Florence E. Rapp
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 490-07-0796	17. INFORMANT'S SIGNATURE OR NAME E. McMichael, Record Clerk	ADDRESS Mo. State San., Mt. Vernon, Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tbc		INTERVAL BETWEEN ONSET AND DEATH over 8 yrs
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 25, 1946, to Oct. 8, 1949, that I last saw the deceased alive on Oct. 8, 1949, and that death occurred at 3:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE C. O. Brasher M. D. (Degree or title)	23b. ADDRESS Mo. State San	23c. DATE SIGNED 10-8-49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 10-9-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Columbia Mo
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DATE REC'D BY LOCAL REG. Oct. 10, 1949	REGISTRAR'S SIGNATURE Cecil Hendricks	25. FUNERAL DIRECTOR'S SIGNATURE Map L. Forrest	ADDRESS M. W. Moore Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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6355

RECEIVED OCT 12 1949

District No. 11
D. G.

District File Number 1049-1116

Date Filed 10-12-49

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 _____
Student Embalmer

Signed May L Forsyth

Licensed Embalmer No. 4252

P. O. Address McKenney, 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.