

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

63-049872

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **12449**

FILED DEC 20 1963

VS 300  
Rev. 4/59

1

2 **2/79**

3

4 **0**

5 **1**

6

7 **1**

8 **1**

9

10

11

12 **52-0**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> , COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3911a Shaw, Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>O.</b> Last <b>RAPERT</b>			4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/25/1913</b>	9. AGE (last birthday) <b>50</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Palatka, Arkansas.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			13a. FATHER'S NAME <b>Silas Rapert</b>		
13b. MOTHER'S MAIDEN NAME <b>Catherine Boster</b>			14. NAME OF HUSBAND OR WIFE <b>Geneva</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of No. <b>No.</b> or unknown) (If yes, give war or dates of <b>Nil.</b> )		16. SOCIAL SECURITY NO. <b>3</b>		17. INFORMANT Address <b>Geneva Rapert, 3911a Shaw, Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of lung with metastases</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20e. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20g. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20h. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <b>6/25/62</b> to <b>12/10/63</b> and last saw <del>him</del> <sup>her</sup> alive on <b>12/10/63</b> Death occurred at <b>4:00 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>C. D. Vermillion, M.D.</i>			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>12/11/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-16-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Doniphan Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Doniphan, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Edwards Funeral Home, Doniphan, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>DEC 18 1963</b>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Elton R. Penelux

Licensed Embalmer No. 4283

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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