

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.

Registration District No. 26

Primary Registration District No. 3002

Registrar's No. 168

1. PLACE OF DEATH:

(a) County Audrain  
 (b) City or town Mexico  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Audrain Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 15 days  
 (Specify whether  
 In this community  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain  
 (c) City or town Rual Mexico  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. R.F.D. #1  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME John Thomas Applebee 141

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

(b) Name of husband or wife Margaret Applebee 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 2, 1865  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>5</u>	<u>18</u>	hr. _____ min.

9. Birthplace Ohio  
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name William Applebee

13. Birthplace Ohio  
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Applebee

(b) Address Mexico Mo.

17. (a) Burial (b) Date thereof Dec. 22, 39  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Earl E. Pugh

(b) Address Mexico, Mo.

19. (a) 12/21/39 (b) Blanche Neely  
 (Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20<sup>th</sup>  
 year 1939 hour 8:00 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec 5, 1939 to Dec 20, 1939  
 that I last saw him alive on Dec 19-1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Uremic poisoning  
 Due to Hypertrophied Prostate gland  
 Due to \_\_\_\_\_

Duration

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death) 12/1

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:  
 (a) Accident, suicide, or homicide (specify) no  
 (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)  
 (e) Means of injury \_\_\_\_\_

23. Signature McKashear (M. D. certifying)  
 Address Mexico, Mo Date signed 12/20/39

RECEIVED

District Health Officer No. 10

District File No. 1-40-122

Date Filed JAN 9 1940

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.....

Earl E. Precht

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

working under my personal supervision.

Signed Earl E. Precht

Licensed Embalmer No. 3189

P. O. Address Mexico, 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, above space should be left blank.**