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22315

FILED OCT 12 1940
Registration District No. **135**

Primary Registration District No. **3010**

Registrar's No. **81**

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

1. PLACE OF DEATH:

(a) County **[Redacted]**

(b) City or town **Carrollton**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2-0**
(Specify whether)

In this community **2**
years, months or days

3. (a) PRINT FULL NAME **Ide Appleberry**

3. (b) If veteran, name war

3. (c) Social Security No. **None**

4. Sex **M** 5. Color or race **W**

6. (a) Single, ~~widowed~~, ~~married~~, ~~divorced~~ **single**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **5** years (Day) (Year) **1874**

7. Birth date of deceased: **24** (Month) **5** (Day) **1874** (Year)

8. AGE:

Years	Months	Days	If less than one day
65	5	13	hr. min.

9. Birthplace **Carroll Co Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **William R. Appleberry**

13. Birthplace **Carroll Co Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Maria S. Appleberry**

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

16. (a) Informant **Ora Appleberry**

(b) Address **Dawn Mo**

17. (a) **Buried** (b) Date thereof **9 4 40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Low Gap Cem**

18. (a) Signature of funeral director **Wells-Marsball**

(b) Address **Carrollton Mo**

19. (a) **9-3-40** (b) **Jetha Haskins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Carroll**

(c) City or town **Carrollton Mo**
(If outside city or town limits, write "RURAL")

(d) Street No. **0**
(If rural, give location)

(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **3**
year **1940** hour **9³⁰** minute **9** A. M.

21. I hereby certify that I attended the deceased from **Aug 16**, 19**40**, to **Aug 31**, 19**40**
that I last saw her alive on **Aug 31st**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** 3 wks

Due to **J2W**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(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?
130 (Specify type of place) While at work? (e) Means of injury

23. Signature **W.B. Atwood** (M. D. or other) **1**
Address **Carrollton Mo** Date signed **9/3/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

VED
Health Officer No. 8,
File Number
10-11-10

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signed R. M. Marshall
Licensed Embalmer No. 21-75-
P. O. Address Carrollton, Va.

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.