S. No. 2
M—2-43
5-17-39
I X35697

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

13672

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 3 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 434

1. PLACE OF DEATH:

(a) County Buchanan

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

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

(d) Length of stay: In hospital or institution 10 da (Specify whether

In this community 55 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 1213 No 10th (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Phillip Brewster Applegate

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Dec (Month) 3 (Day) 1852 (Year)

8. AGE: Years 90 Months 4 Days 9 If less than one day ..... hr. ..... min.

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

10. Usual occupation Retired Bricklayer

11. Industry or business .....

FATHER
12. Name Phillip applegate
13. Birthplace unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name ✓
15. Birthplace ✓ (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs H. G. Powers

(b) Address St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-43 (Month) (Day) (Year)

(c) Place: burial or cremation IOOF Com.

18. (a) Signature of funeral director Fleeman & Son Inc

(b) Address 1946 Colburn

19. (a) 4-14-43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12th year 1943 hour 4 minute 30 P M.

21. I hereby certify that I attended the deceased from April 13th 1943 to ..... 19..; that I last saw h..... alive on ..... 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac decompensation	10 days
Due to Chronic myo Carditis	5 years
Due to General Arteriosclerosis	5 years
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations 93 d

Of autopsy No

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) .....

(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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature H F Munday Coroner (M.D. or other)

Address 404 So 3d St Date signed 4-13-43

1233

(Licensed Embalmer's Statement on Reverse Side) St Joseph Mo

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

Signed Robert L Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph 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.