

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19227

FILED JUL 15 1949

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

BIRTH NO. _____		REG. DIST. NO. <u>121</u>		PRIMARY REG. DIST. NO. <u>5464</u>		Registrar's No. <u>39</u>	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>GREENE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WILHARD</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WILHARD</u>		39	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ross</u> b. (Middle) c. (Last) <u>APPLEBY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 21, 1949</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Sept 9, 1881</u>	
9. AGE (In years last birthday) <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		9. AGE (In years last birthday) <u>67</u> 10. MONTHS <u>9</u> 11. DAYS <u>12</u>	
11. BIRTHPLACE (State or foreign country) <u>Greene Co., Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Samuel S. Appleby</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah E. Kite</u>		14. NAME OF HUSBAND OR WIFE <u>Ora Elizabeth Appleby</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>491-12-2891</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ora E. Appleby</u> ADDRESS <u>Wilhard, Mo.</u>			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolism</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Probable Carcinoma Gastric with rupture.</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>151X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>40 hours</u> <u>3rd max year</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-20</u> , 19 <u>49</u> , to <u>6-21</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>6-21</u> , 19 <u>49</u> , and that death occurred at <u>3:25 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. Charles H. Orr</u>				23b. ADDRESS <u>Ash Grove Mo.</u>		23c. DATE SIGNED <u>6-24-1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>June 24 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Greene Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>7/2/49</u>		REGISTRAR'S SIGNATURE <u>Orma G. Wilson</u> 104		25. FUNERAL DIRECTOR'S SIGNATURE <u>Anna. Polin</u> ADDRESS <u>Walnut Grove</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Greene County Health Office,

County File Number 49-7-45

Date Filed 2-13-49

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 Warren D. Roberts

Licensed Embalmer No. 4005

P. O. Address Ash Grove, 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.