

5. No. 300  
EV. 10.48

FILED APR 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 11933

0100

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 5120 Registrar's No. 120

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>COLUMBIA</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>COLUMBIA</u>	
c. LENGTH OF STAY (in this place) <u>14 YEARS</u>		d. STREET ADDRESS (If rural, give location) <u>ROUTE 6</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ROUTE 6</u>		d. STREET ADDRESS (If rural, give location) <u>ROUTE 6</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>WALTER</u> b. (Middle) <u>JOHN</u> c. (Last) <u>APPLEGARTH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4-13-50</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>3-3-85</u>
9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Boone Co., Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>JOHN W. APPLEGARTH</u>		13b. MOTHER'S MAIDEN NAME <u>MARY MONTGOMERY</u>	
13c. MOTHER'S MAIDEN NAME <u>MARY MONTGOMERY</u>		14. NAME OF HUSBAND OR WIFE <u>ALTA McLEAN APPLEGARTH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-24-3246</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. WALTER J. APPLEGARTH</u>		ADDRESS <u>ROUTE 6, COLUMBIA, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Degeneration</u> ANTECEDENT CAUSES DUE TO (b) <u>CardioRenal Syndrome</u> DUE TO (c) <u>Hypertension - arterial</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
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 <input type="checkbox"/> 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>12-29-48</u> to <u>4-13-50</u> , that I last saw the deceased alive on <u>4-8-50</u> 19 <u>50</u> , and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____		23b. ADDRESS <u>Centerville, Mo</u>	
23c. DATE SIGNED <u>4-13-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
24b. DATE <u>APRIL 14, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY _____	
24d. LOCATION (City, town, or county) (State) <u>POLK CITY, IOWA</u>		DATE REC'D BY LOCAL REG. <u>April 14 1950</u>	
REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Parsons Funeral Service, Columbia</u>	

RECEIVED  
District Health Officer No. 9,  
District File Number

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 Chas L. Zaring

Licensed Embalmer No. 4132

P. O. Address Columbia, Pa.

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.