No. 300
10.48

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

FILED NOV 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36907

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4742

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Children's Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jasper
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Joplin
d. STREET ADDRESS (If rural, give location): 1109 Valley

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3. NAME OF DECEASED (Type or Print): a. (First) Charles b. (Middle) Eugene c. (Last) Apel
4. DATE OF DEATH: (Month) Nov. (Day) 11, (Year) 1950
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: Aug. 28, 1945
9. AGE (In years last birthday): 5 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Joplin, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: James Apel
13b. MOTHER'S MAIDEN NAME: Katherine Willis
14. NAME OF HUSBAND OR WIFE: Child
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: Mrs. James Apel — ADDRESS: 1109 Valley, Joplin, Mo.

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 40

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS — 20 4

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 ☐ NO ☒

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) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-7, 1950, *to* 11-11, 1950, *that I last saw the deceased alive on* 11-11, 1950, *and that death occurred at* 3:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. M. Gilkey MD (Degree or title) — H. M. Gilkey
23b. ADDRESS: 1624 Prof. Bldg
23c. DATE SIGNED: Nov. 11, 1950

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 4
24b. DATE: Nov 11 1950
24c. NAME OF CEMETERY OR CREMATORY: —
24d. LOCATION (City, town, or county) (State): JOPLIN MO

DATE REC'D BY LOCAL REG.: 11-11-50
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: Mrs. E. L. Forster
ADDRESS: K.C. Mo

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....

working under my personal supervision.

Student Embalmer No.....

Signed Lou Clark

Signed.....
Student Embalmer

Licensed Embalmer No. 4216

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.