

FILED MAY 11 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12810**
Registrar's No. **2**

12810
0390

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

BIRTH NO. _____		REG. DIST. NO. 121		PRIMARY REG. DIST. NO. 5464		State File No. 12810		Registrar's No. 2	
1. PLACE OF DEATH a. COUNTY Greene					2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Willard, R.2			c. LENGTH OF STAY (In this place) 40 years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN R/2. Willard, Missouri 0390				
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION The Family Home					d. STREET ADDRESS (If rural, give location) 1				
3. NAME OF DECEASED (Type or Print) a. (First) Flossie			b. (Middle)		c. (Last) Appleby		4. DATE OF DEATH (Month) (Day) (Year) Apr. 27. 51		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH July 30, 1887		9. AGE (In years last birthday) Months Days Hours Min. 63 8 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Springfield, Missouri 0		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Samuel D. Appleby			13b. MOTHER'S MAIDEN NAME Sarah E. Kite			14. NAME OF HUSBAND OR WIFE Unmarried			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs W.H. Jones, Springfield, Mo				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of left ovary ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>						INTERVAL BETWEEN ONSET AND DEATH 11 Months	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 175x						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) Springfield, Mo.		21d. HOW DID INJURY OCCUR?		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I hereby certify that I attended the deceased from July 21, 1950 , to April 27, 1951 , that I last saw the deceased alive on April 25, 1951 , and that death occurred at 5:30 p.m. , from the causes and on the date stated above.									
23. SIGNATURE (Degree or title) Kenneth C. Ogden M.D.				23b. ADDRESS Springfield, Mo.			23c. DATE SIGNED 4-28-51		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr. 29, 1951		24c. NAME OF CEMETERY OR CREMATORY Bellview		24d. LOCATION (City, town, or county) (State) Northeast Springfield, Mo			
DATE REC'D BY LOCAL REG. 5/1/51		REGISTRAR'S SIGNATURE Drew B. Wilson			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Greenwald-Middle Millard				

RECEIVED

Greene County Health Office,

County File Number 51-5-26

Date Filed 5-9-51

MAY 11 1951

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 James W. Wair

Licensed Embalmer No. 4650

P. O. Address Springfield, 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.