

FILED AUG 2 - 1955

STANDARD CERTIFICATE OF DEATH

23409
State File No. 5889
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY OR TOWN St Louis	
c. LENGTH OF STAY (in this place) 4 wks		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Brothers Hosp.		e. STREET ADDRESS (If rural, give location) 24 2823 Lyon St 22490	
3. NAME OF DECEASED (Type or Print) a. (First) Audie		b. (Middle) M.	
c. (Last) Appleton		4. DATE OF DEATH (Month) (Day) (Year) July 5th 1955	
5. SEX Male <input type="radio"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 29 1907
9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder	11. BIRTHPLACE (City and State or Foreign Country) Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. NAME OF HUSBAND OR WIFE Mrs Donna Appleton	
13a. FATHER'S NAME William Appleton		13b. MOTHER'S MAIDEN NAME Fannie Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 432-03-5121	
17. INFORMANT'S SIGNATURE OR NAME Mrs Donna Appleton		ADDRESS 2823 Lyon St	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Glomerulo nephritis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
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 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 checked="" type="checkbox"/> NO <input 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? 593x		22. I hereby certify that I attended the deceased from June 1955, to July 5, 1955, that I last saw the deceased alive on July 5, 1955, and that death occurred at 7:40 a.m., from the causes and on the date stated above.	
23a. SIGNATURE J. W. Dally M.D.		23b. ADDRESS 5703 Mississippi	
23c. DATE SIGNED 7-7-55		24a. BURIAL / CREMATION, REMOVAL (Specify) Burial	
24b. DATE July 8 1955		24c. NAME OF CEMETERY OR CREMATORY St Trinity Lutheran Cem.	
24d. LOCATION (City, town, or county) (State) Lemay, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Fey Funeral Home	
25. ADDRESS Mehleville Mo.		DATE REC'D BY LOCAL REG. JUL 8 1955	
REGISTRAR'S SIGNATURE J. Carl Smith M.D.		REGISTRAR'S SIGNATURE Fey Funeral Home	

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.....
Signature of Student Embalmer

Signed..... *Paul A. Wachter*

Licensed Embalmer No. *478*

P. O. Address *H. H. Smith*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.