

FILED DEC 14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35810

State File No.

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 364

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where diagnosed lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kirksville</u>	c. LENGTH OF STAY (In this place) <u>59 days</u>	c. CITY OR TOWN <u>Armstrong</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Loughlin Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Rt. #1</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Virgil</u>	b. (Middle)	c. (Last) <u>Appleman</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12 9 1955</u>
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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>MAR. 3 1891</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>AUDRAIN Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>BELL Appleman</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA CHRISTIAN</u>	14. NAME OF HUSBAND OR WIFE <u>MAE MERTZ</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS VIRGIL H. APPLEMAN ARMSTRONG</u>	ADDRESS <u>ARMSTRONG</u>
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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) <u>TRANSITIONAL CELL CARCINOMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Mo.</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>URINARY BLADDER WITH METASTASIS TO LIVER</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>181X</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>NONE THIS ADMISSION</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 11-26, 1955, to 12-9, 1955, that I last saw the deceased alive on 12-9, 1955, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Earl Loughlin M.D.</u> (Degree or title)	23b. ADDRESS <u>Kirksville Mo</u>	23c. DATE SIGNED <u>12-9-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>12-10-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Armstrong Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Armstrong Mo</u>
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DATE REC'D BY LOCAL REG. <u>12-10-55</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Carr Funeral Home</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 19 1968

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 *Robert B. Davis*

Licensed Embalmer No. *421*

P. O. Address *Ricksville*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.