

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 22 1960

=60-030190

INDEXED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 867 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b		c. CITY OR TOWN <u>Springfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RFD#1 Box 385</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>W.</u> Last <u>Appleby</u>				4. DATE OF DEATH Month <u>August</u> Day <u>14</u> , Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6 Feb. 1891</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAIRY FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>A. B. APPLEBY</u>			13b. MOTHER'S MAIDEN NAME <u>LAURA JARRETT</u>			14. NAME OF HUSBAND OR WIFE <u>Grace Appleby</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not of unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Grace Appleby (Wife) Springfield, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral vascular collapse</u> DUE TO (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____		
21. I attended the deceased from <u>8-13-60</u> to <u>8/14/60</u> and last saw <u>him</u> live on <u>8/14/60</u> Death occurred <u>10:40</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Full name or title) <u>F. Thomas Moseley M.D.</u>				22b. ADDRESS <u>1636 S. Glenstone Springfield, Missouri</u>		22c. DATE SIGNED <u>8-16-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-17-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENLAWN</u>		23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, Mo.</u>				
24. FUNERAL DIRECTOR <u>KLINGNER MORTUARY, INC. SPRINGFIELD MO.</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>8-18-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

jhc

(Licensed Embalmer's Statement on Reverse Side)

AUG 22 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Catherine Flinn

Licensed Embalmer No. 3714

P. O. Address _____

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.