

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033844

FILED VS OCT 17 1960

042

1000

1058

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

INDEXED

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mercer	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph	Length of stay in 1b 43 days	c. CITY OR TOWN Princeton	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Jackson Middle E. Last Applegate			4. DATE OF DEATH Month October Day 9 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1874	9. AGE (last birthday) 86	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) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William Applegate		13b. MOTHER'S MAIDEN NAME Margaret Campbell	14. NAME OF HUSBAND OR WIFE Unknown		
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. None	17. INFORMANT Address Records State Hosp. #2 St. Joseph, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH 12 Hrs
DUE TO (b) Post operative left inguinal hernia orraphy		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic brain syndrome assoc. with senile brain disease Arteriosclerotic and hypertensive cardiovascular disease		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 type="checkbox"/> NO <input checked="" 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 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 **O.D. on Oct. 9, 1960** and last saw her/him alive on _____
Death occurred at **6:05 P.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Mary B. Ames M.D.	22b. ADDRESS St. Joseph, Missouri	22c. DATE SIGNED 10/9/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 10, 1960	23c. NAME OF CEMETERY OR CREMATORY Martin Funeral Home	23d. LOCATION (City, town, or county) Princeton Missouri

24. FUNERAL DIRECTOR ADDRESS 1117	25. DATE RECD. BY LOCAL REG. Oct. 11, 1960	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF M.B. Ames M.D. MEDICAL CERTIFICATION

14000

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 C. Jones
Licensed Embalmer No. 3258
P. O. Address H. Jones

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.