FEB 20 1930

84

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 2288

Registered No. 1

1. PLACE OF DEATH
County: Polk
Township: E. Looney
City: (No. ..... St. ..... Ward)
Registration District No. 707
Primary Registration District No. 1-936

2. FULL NAME: John W. Apperson
(a) Residence: No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male / female
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED (write the word): widowed
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR ~~WIFE OF~~): Melena Apperson
7. DATE OF BIRTH (MONTH, DAY AND YEAR): Mch 13-1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	80	10		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY): Tennessee

PARENTS
10. NAME OF FATHER: Pearson Apperson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Don't Know
12. MAIDEN NAME OF MOTHER: West
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Don't Know

14. INFORMANT: Georgia Apperson
(Address): Morrisville Mo RR

15. FILED: Jan 17 1930 Mrs. Hattie M. Taylor REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 13 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930, to Jan 13, 1930 that I last saw h~~im~~ alive on Jan 12, 1930, and that death occurred, on the date stated above, at 9-40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Bronchitis
82 R
106 B
97
(duration) 2 yrs. 10 mos. ..... ds.
CONTRIBUTORY (SECONDARY): Arterio Sclerosis &
Cerebral Hemorrhage (duration) ..... yrs. 3 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED: .....
IF NOT AT PLACE OF DEATH: .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF: .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) D E Hammontree M. D.
Jan 14, 1930 (Address) Bolivar Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Slagle
DATE OF BURIAL: Jan 15 1930

20. UNDERTAKER: Hutchison & Blue
ADDRESS: Bolivar Mo