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

Do not use this space.

39919

File No. 101

Registered No. .....

1. PLACE OF DEATH
County Lafayette Registration District No. 461
Township Lexington Primary Registration District No. 3624
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Robert Allen Appleby

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF .....

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 1 - 1930

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	0	10	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Montrose Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Thos. Appleby
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Streator Ill
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Sylvia Clark
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ray Co Mo
(STATE OR COUNTRY)

14. INFORMANT Mrs Thos Appleby
(Address) Lexington Mo

15. FILED Dec 3. 1930 H.W. Fredendall
REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1930, to Dec 2nd, 1930, that I last saw h.... alive on Dec 2nd, 1930, and that death occurred, on the date stated above, at 7 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Catarrhal Pneumonia

107A

CONTRIBUTORY (SECONDARY) 1000 (duration) ..... yrs. ..... mos. ..... ds.

..... (duration) ..... yrs. ..... 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) H.W. Fredendall, M.D
Dec 3, 1930 (Address) Lexington 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 Lexington Mo
DATE OF BURIAL Dec 3 1930

20. UNDERTAKER Ernest Regent
ADDRESS Lexington Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.