

FILED JUL 15 1940

Registration District No. **875**

Primary Registration District No. **6162**

Registrar's No. **141**

1. PLACE OF DEATH:

(a) County **Wernon**
(b) City or town **Wernon**
(c) Name of hospital or institution: **State Hosp. # 3**
(d) Length of stay: In hospital or institution **Seven days**
In this community **Seven days**

3. (a) PRINT FULL NAME **John Applegate**
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**
6. (b) Name of husband or wife **DK**

6. (a) Single, widowed, married, divorced **DK**
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Sept. 30 1865**
(Month) (Day) (Year)

8. AGE: Years **74** Months **7** Days **16**
If less than one day _____ hr. _____ min.

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Miner**

11. Industry or business **1**

12. Name **Aaron Applegate**

13. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Applegate**

15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hosp. Recd.**
(b) Address _____

17. (a) **BURIAL** (b) Date thereof **5-18-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Joplin, MO**

18. (a) Signature of funeral director **HURB BWT UND CO**
(b) Address **212 Joplin St., Joplin, MO**

19. (a) **5/17/40** (b) **Allen V. Hays**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**
(c) City or town **Joplin**
(d) Street No. **224 S. Cox**
(e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **16**
year **1940** hour **0** minute **0 P.M.**

21. I hereby certify that I attended the deceased from **May 9** 1940, to **May 14** 1940,
that I last saw him alive on **May 16** 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death **Senile Dementia**

Due to **Broncho pneumonia**

Other conditions **107W**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
795
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **Wm. A. Bener M.D.**
Address **Wabado mo** Date signed **May 16, 1940**

Duration

PHYSICIAN

Underlines the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 7
District File Number 6/40/952
Date Filed 6/25/40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.