

FILED AUG 21 1940 467

Registration District No. _____

Primary Registration District No. 42 SD

Registrar's No. _____

I. PLACE OF DEATH:

(a) County Andrew
 (b) City or town Anna Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Verona General Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days (Specify whether
 In this community 23 years years, months or days)

3. (a) PRINT FULL NAME Ester Apple 140

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 3 1919
 (Month) (Day) (Year)

8. AGE: Years 20 23 Months 10 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Laurie County
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name E. U. Apple

13. Birthplace Jade County
 (City, town, or county) (State or foreign country)

14. Maiden name Laura Ester

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

16. (a) Informant Dr. F. Avery Watson

(b) Address Verona Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 1940
 (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park Cemetery

18. (a) Signature of funeral director Wear, Marshall

(b) Address Verona Funeral Home Anna Mo

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
 (c) City or town Anna Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. 222 N. Second
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28
 year 1940 hour: 2:00 minute 20 P. M.

21. I hereby certify that I attended the deceased from July 25 1940
1940, 19 to July 27, 1940, 19 ;
 that I last saw her alive on July 27, 1940, 19 ;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure
Due to an old chronic heart lesion.

Due to Peripheral Circulatory Failure 12 hrs

Due to Hypertension of an unknown allergy.

Other conditions Chronic Mitral Insuff. 10 yrs
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

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? _____
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
418 While at work? 0 (Specify type of place) (e) Means of injury 2

23. Signature F. Avery Watson (M. D. or other) D. O.

*Address VERONA GEN HOSP. Date signed 7-28-40

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

RECEIVED

District Health Officer No. 6,

District File Number 8 HO - 2481

Date Filed AUG 19 1940

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 Thayer

Registered Apprentice No. _____

working under my personal supervision.

Signed Oscar L. Marsh

Licensed Embalmer No. 3812

P. O. Address Quincy Mo.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25-577**

Registration District No. **467 475**

Primary Registration District No. **4280 5639**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Lawrence**
(b) City or town **Verona**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME **Ester Apple**

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **8**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased **Sept 3 1919**
(Month) (Day) (Year)

8. AGE: Years **20** Months **10** Days **24** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Jan 11-41** (b) **A. J. Prudig**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

DEATH CERTIFICATION

20. DATE OF DEATH Month **July** day **27**
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
Means of injury _____

23. Signature **F. A. Watson** (M. D. or other) _____

Address **Verona Iron Works** _____
Date signed _____

SUPPLEMENTAL

FALL LEAVES USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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