DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31242

Registration District No. 1

Primary Registration District No. 112

Registrar's No. 222

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

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Kirksville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Walford (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 48 hrs (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Schuyler
(c) City or town: Queencity (If outside city or town limits, write "RURAL")
(d) Street No.: 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Cora Maude Applegate
3. (b) If veteran, name war: None
3. (c) Social Security No.:
4. Sex: female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Arthur
6. (c) Age of husband or wife if alive: 63 years
7. Birth date of deceased: November 21 1881 (Month) (Day) (Year)

8. AGE: Years 58 | Months 10 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace: Schuyler Co (City, town, or county) MO (State or foreign country) 0
10. Usual occupation: House Work 0
11. Industry or business: none 9
MOTHER FATHER
12. Name: Joseph B. Alexander
13. Birthplace: Schuyler Co (City, town, or county) MO (State or foreign country)
14. Maiden name: Jenny McCullery
15. Birthplace: Nat Known (City, town, or county) (State or foreign country)
16. (a) Informant: Culver Applegate
(b) Address: Cream City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: New Harmony Cem
18. (a) Signature of funeral director: Wm R West
(b) Address: Queencity Mo
19. (a) Sept 23/40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21 year 1940 hour 12:30 minute A. M.

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

	Duration
Immediate cause of death: Septicaemia (streptococcic)	48 hrs.
Due to: infection of a deeply contused & lacerated wound in	
Due to: heel of left foot, produced Wed. p.m.	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: none
Of operations: none
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? 3
While at work? (Specify type of place) (e) Means of injury: 3

23. Signature: Roy M. Koch (M. D. or other) DO
Address: Kirksville Mo Date signed 9/24/40

(Licensed Embalmer's Statement on Reverse Side)

194 Pg 99

RECEIVED
District Health Officer No. 10
District File Number 10-40-2000
Date Filed

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

Signed Wm N West

Licensed Embalmer No. 2882

P. O. Address Queen City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

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

. 2B
21-40
X22659

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STANDARD CERTIFICATE OF DEATH

State File No. 31242

Registration District No. 1 Primary Registration District No. 1 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville (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 years, months or days) In this community

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.

3. (a) PRINT FULL NAME Cora Maude Applegate

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 58 Months 10 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21 year 1940 hour minute M.

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

Immediate cause of death Septicemia Streptococcic

Due to Infection of a deeply contused and lacerated wound in heel of left foot.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 194 19

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) accident

(b) Date of occurrence Sept. 19, 1940

(c) Where did injury occur? Queen City (City or town) Mo. (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? farm HOME (Specify type of place)

While at work? yes (housework) (e) Means of injury Screen door slammed against left heel.

23. Signature Roy M. Wolf (M.D. or other)

Address Kirksville Mo. Date signed 12/3/40