

W. H. Appleberry

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36258

State File No.

Registrar's No.

991

FILED NOV 25 1940

Primary Registration District No. 4465

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

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Flat River Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20
(Specify whether
In this community 20
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francois
(c) City or town Flat River
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29
year 1940 hour 8 minute 30 A.M.
21. I hereby certify that I attended the deceased from April
_____, 1940, to Sept 29, 1940
that I last saw her alive on Sept 29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis

Due to Hypertension
atherosclerosis

Due to _____
Other conditions HTA
(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?
WA
(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature W. H. Appleberry (M. D. or other) _____
Address Flat River Mo. Date signed 10-1-40

3. (a) PRINT FULL NAME Lillie Cleveland Bloom

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 _____

6. (b) Name of husband or wife Ed Bloom 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Feb 4 1875
(Month) (Day) (Year)

8. AGE: Years 65 Months 09 Days 25
If less than one day hr. _____ min. _____

9. Birthplace Missouri St. Genevieve Co.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name ROBERT CHEVELAND
13. Birthplace STE. GENEVIEVE CO. MISSOURI
(City, town, or county) (State or foreign country)

{ 14. Maiden name MARY ELIZABETH BURGESS
15. Birthplace Montgomery Co. Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Fernand Bloom
(b) Address Flat River, Mo.

17. (a) Burial (b) Date thereof 10-1-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Flat River Mo.

18. (a) Signature of funeral director Caldwell Bros
(b) Address Flat River Mo.

19. (a) 10/1/40 (b) W. H. Appleberry MD
(Date received local registrar) (Registrar's signature)

1015
6190
7090
7120
6610
6385
1365
11085

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.