

No. 2
-13-40
-17-39
X23159

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11153

Registration District No. 461 Primary Registration District No. 3024 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Lexington
(c) Name of hospital or institution: city
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community Life years, months or days)

3. (a) PRINT FULL NAME HARRY JOE APPLEY
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced D
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 22 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 10 15 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Thomas A. Appleby
13. Birthplace Strutts Mo
(City, town, or county) (State or foreign country)
14. Maiden name Sylvia Clark
15. Birthplace Hardin Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas A. Appleby
(b) Address Lex. Mo.

17. (a) Burial (b) Date thereof 3-8-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington Mo

18. (a) Signature of funeral director W. W. Smith
(b) Address Lex. Mo.

19. (a) 3-8-41 (b) Welia Bates
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 7
year 1941 hour 6 minute 30 P. 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 unknown
Had no medical attention
Due to while alive -
Mother states it had
Died of measles & died in a
convulsion -

Other conditions Others in family had
(Include pregnancy within 3 months of death)
measles & small pox -

Major findings:
Of operations _____
Of autopsy 25

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? 8000

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

23. Signature Appleby (M. D. or other) P
Address Lexington Date signed 4/3/41

RECEIVED
District Health Officer No. 8,
District File Number
14-10-41
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.....

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

Not Embalmed.

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, fact should be so stated above.