

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18308
Registrar's No. 42

Registration District No. 494

Primary Registration District No. 3025

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield, Mo.
(c) Name of hospital or institution: 223 Shelby St
(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)

3. (a) PRINT FULL NAME Norman Applegate
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex M **5. Color or race** W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Anna
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 19 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 8 Days 15 If less than one day _____ hr _____ min

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Thomas Applegate

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

14. Maiden name Rachael

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

16. (a) Informant's own signature Katherine Beard

(b) Address 223 Shelby Brookfield

17. (a) Burial, cremation, or removal Burial **(b) Date thereof** May 16 1941
(Month) (Day) (Year)

(c) Place: burial or cremation Brookfield, Mo.

18. (a) Signature of funeral director James D. Darden

(b) Address Brookfield, Mo.

19. (a) Date received local registrar 5/16/41 **(b) Registrar's signature** John Lucas
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Linn
(c) City or town St. Catharines, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. #3 (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1941 hour 5 minute 14 A. M.
21. I hereby certify that I attended the deceased from May 12, 1941, to May 14, 1941;
that I last saw him alive on May 14, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 3 1/2
Chronic Interstitial Nephritis 3 1/2
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) None

PHYSICIAN
Underline the cause to which death should be charged statistically

Major findings:
Of operations _____
Of autopsy None

22. If death was due to external cause, 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) (e) Means of injury _____
23. Signature W. C. Enright, Jr. (M. D. or other)
Address Brookfield, Mo. Date signed 5/16

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

James B. McCelland, Registered Apprentice No. 224
working under my personal supervision.

Signed

James B. McCelland

Licensed Embalmer No.

3595

P. O. Address

Brookfield, Ill.

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.