FILED SEP 11 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

28907

1. PLACE OF DEATH
County Montgomery — Registration District No. 593
Township Prairie — Primary Registration District No. 4351
City New Florence Mo. (No. 1, St. ..... Ward) — File No. 9 — Registered No. .....

2. FULL NAME CAROL JEAN APPLETON

(a) Residence, No. ..... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	Colored	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 1, 1941

7. AGE — YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. NONE

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ~~Silk~~ Sick Infant

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Florence Mo

FATHER

13. NAME George Appleton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nashville Tenn

MOTHER

15. MAIDEN NAME Mabel Jane Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mineola Mo

17. INFORMANT (ADDRESS) Mrs. Mabel Jane Johnson New Florence Mo

18. BURIAL, CREMATION, OR REMOVAL — PLACE New Florence Mo DATE Aug 1 1941

19. UNDERTAKER (ADDRESS) None

20. FILED 8/18 1941 James O. Helm Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 1, 1941

22. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1941, to Aug 1, 1941
I last saw h... alive on 8-1, 1941. Death is said to have occurred on the date stated above, at 11:30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Premature Birth 7 Months.	

Other contributory causes of importance: 159

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
.....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No,
If so, specify .....
(Signed) James O. Helm, M. D.
(Address) New Florence Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

No. 2B
8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28907

Registration District No. 593 Primary Registration District No. 4351 Registrar's No.

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town New Florence
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Montgomery
(c) City or town NEW FLORENCE
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Carol J. Appleton
3. (b) If veteran, name war.
3. (c) Social Security No.

4. Sex F | 5. Color or race B | 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Aug (Month) 1 (Day) 1941 (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
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) (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) 10-10-4 (Date received local registrar) Jones O. Helm MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 1
year 1941 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (c) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY