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23159

FILED MAR 9 1942

Registration District No. 399

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

5186

State File No.

Registrar's No.

561

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

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (c) Name of hospital or institution:  
St. Mary's Hosp. B.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 33 yrs  
 years, months or days

3. (a) PRINT FULL NAME William H. Appleyard

(b) If veteran, name war No (c) Social Security No. 275-05-682

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Jessie Appleyard 6. (c) Age of husband or wife if alive 59 years  
 7. Birth date of deceased Dec. 19, 1883  
 (Month) (Day) (Year)

8. AGE: Years 58 Months 1 Days 18 If less than one day  
 hr. \_\_\_\_\_ min.

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

10. Usual occupation Mechanic

11. Industry or business Nat. Cash Register

12. Name No Record

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

14. Maiden name " " (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Jessie Appleyard

(b) Address 2946 Jackson

17. (a) Burial (b) Date thereof 2/10/42  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cem.

18. (a) Signature of funeral director Thos. E. Quirk

(b) Address 4316 Troost

19. (a) 9/1/42 (b) M. M. Crowe  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2946 Jackson  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 7  
82 year 42 hour 10:25 P.M. minutes M.

21. I hereby certify that I attended the deceased from May 4, 1935 to Feb 7, 1942  
 that I last saw h. alive on Feb 7, 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Recurrent Carcinoma Sigmoid Duration 4 1/2 yrs

Due to: \_\_\_\_\_  
 Due to: 46E

Other conditions (Include pregnancy within 3 months of death)

Major findings: Carcinoma of sigmoid  
 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)  
 (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 Lawrence P. Engel (M. D. or other) M.D.  
 Address Playa Med. Bldg Date signed 2/9/42

ME

**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

*Thomas E. Jank*

Licensed Embalmer No.

3775

P. O. Address

*N. C. Md*

**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.**