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FILED MAY 4 1944

Registration District No. **360**

Primary Registration District No. **6225**

Registrar's No. **71**

1. PLACE OF DEATH

(a) County **Boone**  
(b) City or town **Boone - Washington**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**State Hosp # 3 20**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **6 months 14 days**  
(Specify whether  
In this community **Some**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Cedar** <sup>108</sup>  
(c) City or town **Stockton**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **None**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **William M. Sappington**

3. (b) If veteran, name war **0** Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **0** 6. (c) Age of husband or wife if alive **8** years

7. Birth date of deceased **Aug 8 1859**  
(Month) (Day) (Year)

8. AGE: Years **84** Months **7** Days **29** If less than one day hr. min.

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

10. Usual occupation **None**

11. Industry or business **0**

MOTHER FATHER { 12. Name **Wm M Sappington**  
13. Birthplace **Boone Co Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mary R Ballinger**  
15. Birthplace **Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Wm Reed**  
(b) Address **Nebraska Mo**

17. (a) **Removal** (b) Date thereof **Apr 7 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Stockton Mo**

18. (a) Signature of funeral director **Harp Funeral Service**  
(b) Address **Nebraska Mo**

19. (a) **4-8-44** (b) **Fozel B. Burch**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **7** year **1944** hour **3** minute **00** P.M.

21. I hereby certify that I attended the deceased from **Sept 27** 1943 to **April 7** 1944  
that I last saw him alive on **April 7** 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cryptogenic Pulmonary Congestion**  
Duration **0**

Due to **Chr. Deg Myocarditis**

Due to **Sen. Arteriosclerosis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **0**  
Of autopsy **0**

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) **0**  
(b) Date of occurrence **0**  
(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? **0**

While at work? (Specify type of place) (e) Means of injury **0**

23. Signature **Wm M Sappington** (M. D. or other)  
Address **Nebraska** Date signed **4/7/44**

1331

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

MAY 4 1944

JUL 11 1944

RECEIVED

District Health Officer No. 7,  
District File Number 4-44-551  
Date Filed 5-3-44

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 Mack A. Braswell

Licensed Embalmer No. 2529

P. O. Address Nevada mo.

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.