

**FILED** OCT 12 1945

Registration District No. **274**

Primary Registration District No. **3052**

Registrar's No. **252**

**1. PLACE OF DEATH:**

(a) County **Pettis**  
(b) City or town **Sedalia**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Home**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **7 Yrs** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **William W. Appleby**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 0 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Wid** ✓  
6. (b) Name of husband or wife **Fannie Appleby**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Dec. 27 1870**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>74</b>	<b>10</b>	<b>29</b>	_____ hr. _____ min.

9. Birthplace **Morgan County Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Harmon Appleby**  
13. Birthplace **Ohio**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Elizabeth McCubbins**  
15. Birthplace **Morgan County Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Dave Appleby**

(b) Address **1317 S. Grand**

17. (a) **burial** (b) Date thereof **Sep. 28 1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crown Hill Cem.**

18. (a) Signature of funeral director **McLaughlin Bros.**

(b) Address **Sedalia**

19. (a) **10-1-45** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Pettis** **80**  
(c) City or town **Sedalia** **6**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1317 S Grand** **4**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Sep** day **28**  
year **1945** hour **7** minute **15** P.M.

21. I hereby certify that I attended the deceased from **Sep 22**  
~~Sept 24~~ 1945 to **Sep 26** 1945  
that I last saw him alive on **Sep 26** 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary insufficiency**  
**Arterio Sclerosis**

Due to \_\_\_\_\_

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **gfu**  
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)  
(c) Means of injury \_\_\_\_\_  
23. Signature **H. J. Bishop** (M. D. or other) **md.**  
Address **Sedalia Mo** Date signed **9-27-45**

10-10-45-

**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 \_\_\_\_\_

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.**