

FILED NOV 6 1945

State File No.

Registration District No. 96

Primary Registration District No. 4138

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Buffalo
(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 28 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
(c) City or town Buffalo
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME GEORGE J APPELGATE

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased Jan 5 1861
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 3 If less than one day hr. min.

9. Birthplace Vincennes Ind
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business.....

12. Name Elizabeth Applegate
13. Birthplace Franklin
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth
15. Birthplace Franklin
(City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address Buffalo Mo

17. (a) Burial (b) Date thereof 9-10-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wal Law

18. (a) Signature of funeral director L B Jones
(b) Address Buffalo Mo

19. (a) 10-3-45 (b) Thomas Peter
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8
year 1945 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from July 1, 1945, to Sept 8, 1945
that I last saw him alive on Sept 11
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of prostate gland
Due to..... Duration 2 yrs

Other conditions Senility
(Include pregnancy within 5 months of death)

Major findings:
Of operations.....
Of autopsy 5/16 none
none

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

23. Signature St. Plummer (M.D. or other) M.D.
Address Buffalo Mo Date signed 10-2-45

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

MOTHER FATHER

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.....

Leonard James

Licensed Embalmer No.

2508

P. O. Address.....

Buffalo 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.

Registration District No. 96 Primary Registration District No. 4158

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Buffalo
(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

3. (a) PRINT FULL NAME George J. Applegate

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased Jan 5 (Month) (Day) (Year)

8. AGE: Years 84 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) Ind.

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 Mrs. Geo. Applegate
(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) _____ (Date received local registrar) (b) G. R. P. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

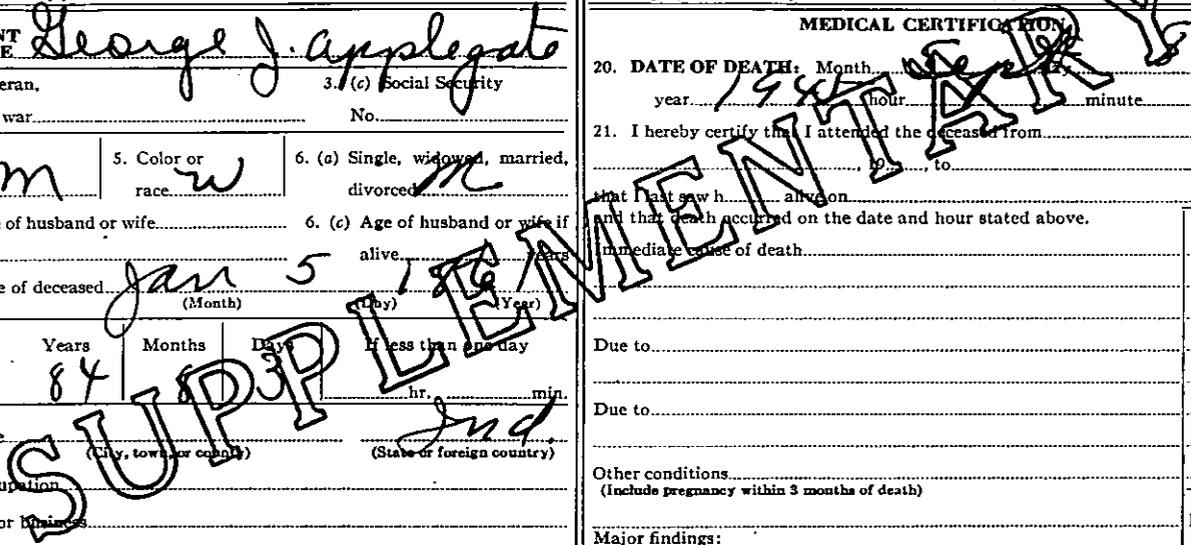
Underline the cause to which death should be charged statistically.

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)
(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 _____ (M. D. or other) _____
Address _____ Date signed _____

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



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