

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED JAN 15 1946 STANDARD CERTIFICATE OF DEATH

State File No. 411465

Registration District No. 118

Primary Registration District No. 5437

Registrar's No. 149

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Rural "Bourboise Sup."
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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

HARRY APLIN

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 Widowed

6. (b) Name of husband or wife Linnie Mae Aplin

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

7. Birth date of deceased February
(Month)

10 1864
(Day) (Year)

8. AGE: Years Months Days
81 10 8

If less than one day
hr. min.

9. Birthplace CARTERSBURG
(City, town, or county)

INDIANA
(State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Charles Aplin

13. Birthplace _____
(City, town, or county)

Indiana
(State or foreign country)

14. Maiden name Biddle

15. Birthplace _____
(City, town, or county)

Penn.
(State or foreign country)

16. (a) Informant Oliver Aplin

(b) Address Bland, Mo. Route

17. (a) Burial (b) Date thereof 12 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bowen Cemetery

18. (c) Signature of funeral director Welford H. H. Winter

(b) Address Owensville, Mo.

19. (a) Dec 19-45 (b) Robert M. Murray
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade ?
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Bland, Mo. Route 1
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18
year 1945 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from October
1944 to Dec 18 1945
that I last saw him alive on Dec 16 1945
and that death occurred on the date and hour stated above.

Immediate cause of death uremia
Due to Prostatitis & cystitis 2 years
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 sta-
tistically.

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 William H. Breuer (M. D. or other) _____
Address _____ Date signed Dec 19-45

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 7-14-46

AUG 1 1945

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.