

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16850

State File No. ....

FILED JUN 14 1954

No. 300  
10-48

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>218</u>	
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sedalia</u>		c. LENGTH OF STAY in this place <u>9 hrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>WARSAW</u>		<u>00801</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hosp.</u>				d. STREET ADDRESS <u>(If rural, give location)</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>MOLLIE</u>		b. (Middle) <u>(None)</u>		c. (Last) <u>SIMPSON</u>	
4. DATE OF DEATH		(Month) <u>June</u>		(Day) <u>8</u>		(Year) <u>1954</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>Mar 28, 1873</u>	
9. AGE (In years last birthday) <u>81</u>		if UNDER 1 YEAR Months <u>2</u> Days <u>10</u>		if UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cass Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Sam Applegate</u>		13b. MOTHER'S MAIDEN NAME <u>unknown Muller</u>		14. NAME OF HUSBAND OR WIFE <u></u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs John Blake Warsaw, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Infarction</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Dis.</u> DUE TO (c) <u></u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Cholecystitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS.</u> <u>4 yrs.</u> <u>3 YEARS</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4200</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>50</u> , to <u>8 June</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>7 June</u> , 19 <u>54</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>David H. Allen M.D.</u>				23b. ADDRESS <u>Warsaw Mo</u>		23c. DATE SIGNED <u>June 9, 1954</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 10, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Austin Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Austin Mo</u>	
DATE REC'D BY LOCAL REG. <u>6-12-54</u>		REGISTRAR'S SIGNATURE <u>Warren County Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Rose</u>		ADDRESS <u>Warsaw</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*John J. Reser*  
Licensed Embalmer No. 4098

P. O. Address Warsaw

**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.