

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **22765**

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>5464</u>		Registrar's No. <u>666</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rte 2, Willard, Mo</u>		c. LENGTH OF STAY (In this place) <u>45 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rte 2, Willard, Missouri</u>		d. STREET ADDRESS (If rural, give location) <u>0390</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The Family Home</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ellen</u>			b. (Middle) <u>Burge</u>		c. (Last) <u>Appleby</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 10, 1954</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Sept. 5, 1883</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Month <u>10</u> Days <u>5</u>	IF UNDER 1 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Invalid) Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Springfield, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Samuel D. Appleby</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah E. Kite</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Jane Appleby, R. 2, Willard, 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>Lobar pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>490X</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) (m.)		21e. INJURY OCCURRED WHILE AT 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>July 8, 1954</u> to <u>July 10, 1954</u> that I last saw the deceased live on <u>July 8, 1954</u> and that death occurred at <u>8:30 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Herbert O. O'Neil</u>				23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>7-12-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-12-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hell-View Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>N. E. Springfield, Mo</u>	
DATE REC'D BY LOCAL REG. <u>7-12-54</u>		REGISTRAR'S SIGNATURE <u>Edith Williams</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Greenwade-Windle, Willard MO</u>			

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

JAN 29 1959

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 _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.