

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023959

STATE FILE NUMBER

FILED JUL 7 1959

Registration District No. 374

Primary Registration District No.

Registrar's No. 24

300
1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Worth		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Worth	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Allen Twp		c. CITY OR TOWN Denver, Mo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2 Mi Se of Denver Mo		d. STREET ADDRESS Rural	
Length of stay in lb 70 Yrs		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle FRANKLIN Last ABPLANALP			4. DATE OF DEATH Month June Day 24 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 19, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Worth Co Mo
13a. FATHER'S NAME Casper Abplanalp		13b. MOTHER'S MAIDEN NAME Madgalene Stahl	14. NAME OF HUSBAND OR WIFE Effie Abplanalp
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Ora Mills Abplanalp Address Denver, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Sclerosis Bronchial Asthma. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4500			INTERVAL BETWEEN ONSET AND DEATH 2 or 3 yrs
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from 1958 to June 4, 1959 and last saw her alive on June 4, 1959 . Death occurred at 2:30 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE D. S. D. Harding Dr. (Degree or title)		22b. ADDRESS Albany Mo.	
		22c. DATE SIGNED June 27, 1959	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 26, 1959	
23c. NAME OF CEMETERY OR CREMATORY Miller Cemetry		23d. LOCATION (City, town, or county) (State) Rural Denver, Mo	
24. FUNERAL DIRECTOR Kermit Bran ADDRESS Denver, Mo		25. DATE RECD. BY LOCAL REG. June 30 - 1959	
		26. REGISTRAR'S SIGNATURE Bowdrey Kibbe	

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 John Andrews, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed John Andrews
Licensed Embalmer No. 4211
P. O. Address Grant City, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.