

URIAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002288

ENDED

FILED VS. JAN 12 1960 170

Registration District No. _____ Primary Registration District No. 3033 Registrar's No. 1

STATE FILE NUMBER

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Laclede</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Laclede</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u> | | Length of stay in 1b <u>50 yrs.</u> | | c. CITY OR TOWN <u>Lebanon</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wallace Hospital</u> | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>450 Bland</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Edward Apppling</u> | | | | 4. DATE OF DEATH Month Day Year <u>Jan. 4, 1960</u> | | | |
| 5. SEX <u>m</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10/1/1904</u> | |
| 9. AGE (last birthday) <u>55</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Furniture store operator</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Redland Calif. U. S. A.</u> | | 11. BIRTHPLACE (City and state or country) | |
| 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | | | 13a. FATHER'S NAME <u>Charles E. Apppling</u> | | 13b. MOTHER'S MAIDEN NAME <u>Emma Martin</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Grace Apppling</u> | | | | 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>493-10-6008</u> | |
| 17. INFORMANT <u>Mrs. Grace Apppling Lebanon</u> | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia with Convulsions</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a). <u>Poly cystic Kidneys</u> | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 <u>9-16-1949</u> to <u>1-4-1960</u> and last saw her/him alive on <u>1-3-1960</u> Death occurred at <u>2:05 A.m</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Paul A. Jenkins M.D.</u> | | | | 22b. ADDRESS <u>Knight Bldg. Lebanon. Mo</u> | | 22c. DATE SIGNED <u>JAN. 5, 1960</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>1/5/1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Lebanon, Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>D.M. Howe Lebanon Mo.</u> | | | | 25. DATE REG. BY LOCAL REG. <u>1-5-1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Hella L. Hlay</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.