DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 12 1940

Registration District No. 135

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31642

Primary Registration District No. 3010

Registrar's No. 80

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

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Carroll
(c) City or town Carrollton
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Orville Applebury
3. (b) If veteran, name war
3. (c) Social Security No. None

4. Sex F
5. Color or race W
6. (a) Single, ~~widowed~~, married, ~~divorced~~ Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased 10 (Month) 2nd (Day) 1868 (Year)

8. AGE: Years 71 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Carroll Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business 0

MOTHER FATHER
12. Name William R Applebury
13. Birthplace Carroll Co (City, town, or county) Mo (State or foreign country)
14. Maiden name Mariah Susan Applebury
15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant O. A. Applebury
(b) Address Baker Mo
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-4-40 (Month) (Day) (Year)
(c) Place: burial or cremation Low Gap Cemetery
18. (a) Signature of funeral director Willis-Marshall
(b) Address Carrollton Mo
19. (a) 9-3-40 (Date received local registrar) (b) Ruth Haskins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 1st year 1940 hour 10 a.m. minute 0 M.
21. I hereby certify that I attended the deceased from Aug 29th, 1940, to Sept. 1st, 1940, that I last saw h alive on Aug 31st, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to	
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 statistically.

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. S. Atwood (M. D. or other)
Address Carrollton Mo Date signed 9-3-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 10-4-40

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed W. B. Sellers

Licensed Embalmer No. 3861

P. O. Address Brooklyn

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.