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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31643

Registration District No. 135 — Primary Registration District No. 8010 — Registrar's No. 81

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

1. PLACE OF DEATH:
(a) County Ca[illegible]
(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 0 (Specify whether
In this community years, months or days)

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

3. (a) PRINT FULL NAME Ida Appleberry
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 4 (Month) 5 (Day) 1874 (Year)
8. AGE: Years 65 Months 5 Days 13 If less than one day hr. min.
9. Birthplace Carroll Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Hswk
11. Industry or business
FATHER 12. Name William R. Appleberry
13. Birthplace Carroll Co (City, town, or county) Mo (State or foreign country)
MOTHER 14. Maiden name Martha E. Appleberry
15. Birthplace (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Ora Appleberry
(b) Address Dawn Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 4 40 (Month) (Day) (Year)
(c) Place: burial or cremation Low Gap Cem
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 3 year 1940 hour 9 30 minute a. M.
21. I hereby certify that I attended the deceased from Aug 16, 1940, to Aug 31, 1940
that I last saw her alive on Aug. 31st, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	3 wks
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. G. Atwood (M. D. or other)
Address Carrollton Mo Date signed 9/3/40

(Licensed Embalmer's Statement on Reverse Side)

VED
t Health Officer No. 8,
File Number
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 R. M. Marshall

Licensed Embalmer No. 21-75

P. O. Address Carrollton M

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.