

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022218

STATE FILE NUMBER

FILED JUL 13 1959

Registration District No. 227

Primary Registration District No. 3046

Registrar's No. 66

S. 300
v. 1-57

81

1. PLACE OF DEATH a. COUNTY MONITEAU		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY MONITEAU	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR California TOWN California		c. CITY OR TOWN California	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If outside, give location) 06 & 1/2	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES MARION APPERSON		4. DATE OF DEATH Month Day Year JUNE 27 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 MARCH 14-1874
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD	9b. KIND OF BUSINESS OR INDUSTRY NO	9c. AGE (In years last birthday) 85	9d. IF UNDER 1 YEAR Months Days Hours Min. 3 13
10a. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BIRTHPLACE (City and state or country) California Mo	
13a. FATHER'S NAME MANSEFIELD APPERSON		13b. MOTHER'S MAIDEN NAME MALINDA GUINN	
14. NAME OF HUSBAND OR WIFE HARRIETT ANN DIXON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 495-07-9936		17. INFORMANT Address Mrs. Bernad Houser California Mo	
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene left leg Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio-sclerotic hyperplasia DUE TO (c) 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral hemorrhage Dec 1956 331x		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. Month, Day, Year p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION June 6, to June 27		20f. COUNTY STATE California	
21. I attended the deceased from Death occurred at June 6, to June 27 and last saw him alive on June 27 59 m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Edgar L. Roberts M.D.	
22b. ADDRESS California		22c. DATE SIGNED 6/28/59	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 6-29-1959	23c. NAME OF CEMETERY OR CREMATORY CITY Cemetery	23d. LOCATION (City, town, or county) (State) California Mo
24. FUNERAL DIRECTOR Hugh E. Williams	25. DATE RECD. BY LOCAL REG. 6/29/59	26. REGISTRAR'S SIGNATURE H. E. Williams	

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

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
Signature of Student Embalmer

Signed *Hugh E. Williams*

Licensed Embalmer No. *3537*

P. O. Address. *California M*

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.