WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Montgomery Co.

Township Montgomery

or

Village

or

City (NO. St.: Ward)

Registration District No. 592

Primary Registration District No. 5790

File No. 34319

Registered No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mrs. Malinda Maupin.

3

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widow

DATE OF BIRTH: Oct (Month) 24 (Day) 1848 (Year)

AGE: 66 yrs. 11 mos. 25 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 131 16

BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

NAME OF FATHER: J. Holt

BIRTHPLACE OF FATHER (City or town, State or foreign country): Not Known

MAIDEN NAME OF MOTHER: Mrs. Brown

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Maupin

(ADDRESS) Montgomery City

Filed Nov, 1915. E. W. Linsley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 23, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 16, 1915, to Oct 21, 1915, that I last saw her alive on Oct 21, 1915, and that death occurred, on the date stated above, at a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion from Senility, 120

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY): Chronic Nephritis

(Duration) Unknown yrs. ___ mos. ___ ds.

(Signed) G. E. Ellings M. D.

Oct 23 1915 (Address) Montgomery City

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Hopwell

DATE OF BURIAL: Oct 24 1915

UNDERTAKER: J. W. Kirkham

ADDRESS: Hopwell Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country) .....

PARENTS

NAME OF FATHER .....

BIRTHPLACE OF FATHER
(City or town, State or foreign country) .....

MAIDEN NAME OF MOTHER .....

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191...., that I last saw h..... alive on ....., 191...., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS