

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOV 28 1930

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

Do not use this space.

35098

1. PLACE OF DEATH
 County Shelby Registration District No. 827
 Townshp. Clay Primary Registration District No. 4500
 City Clarance (No. _____) St. _____ Ward _____

2. FULL NAME Benjamin Franklin Maupin
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12 1844

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>85</u>	<u>9</u>	<u>23</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Retired Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Augusta Co Va
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER James Maupin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Va
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mrs Kennerly

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Va
 (STATE OR COUNTRY)

14. INFORMANT Mrs Frank Maupin
 (Address) Clarance Mo

15. FILED 10/6 1930 Ray Hamilton
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 5 1930

17. HEREBY CERTIFY, That I attended deceased from Oct. 3, 1930, to Oct. 5, 1930 that I last saw him alive on Oct. 5, 1930 and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
122H
137 Artemia
137
122H (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Seizure (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

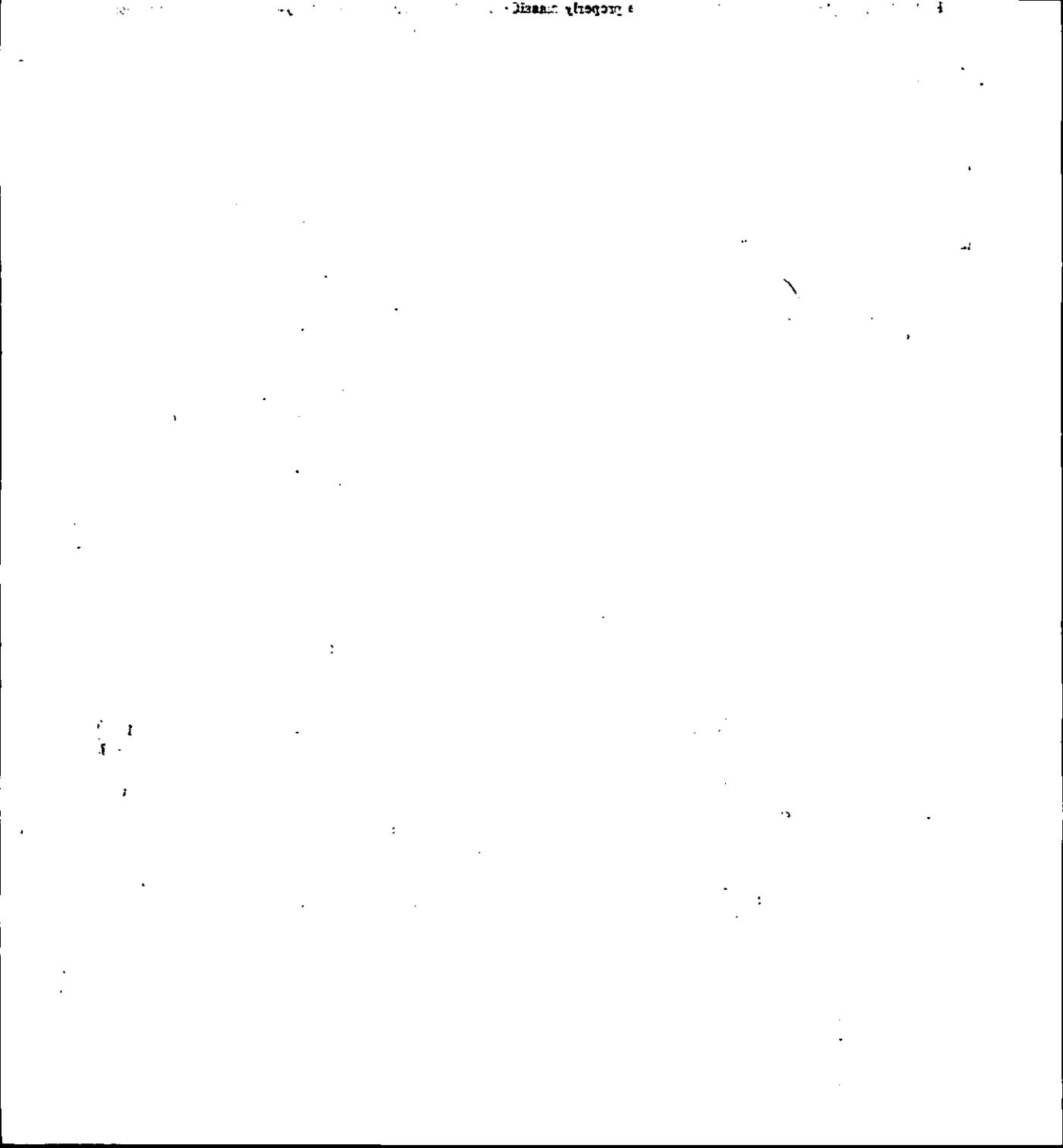
WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) Frank H Roy, M. D.
10/6, 1930 (Address) Clarance Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maud Cemetery DATE OF BURIAL Oct 7 1930

20. UNDERTAKER Hamilton and Co ADDRESS Clarance

740



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greely Registration District No. 827 File No.
Towship Primary Registration District No. 4500 Registered No. 16
City Clarence (No.) St. Ward)

2. FULL NAME

Benjamin Franklin Marpin

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) SM

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 5 1930

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

THE CAUSE OF DEATH WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

retained - hypertrophy of prostate and nephritis

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

CONTRIBUTORY (SECONDARY) Senility (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH DATE OF
WAS THERE AN AUTOPSY
WHAT TEST CONFIRMED DIAGNOSIS
(Signed)....., M. D.
, 19 (Address)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 10/6 30 Ray Hamilton REGISTRAR

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

CAUSE OF DEATH TO BE PROPERLY CLASSIFIED IT MUST BE PROPERLY CLASSIFIED

S-35698