

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

Do not use this space.

3584

File No. _____
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH
113 County North
Township Smith
City _____ (No. _____)

Registration District No. 903
Primary Registration District No. 6911

2. FULL NAME James F Maudlin
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
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 M
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Gertrude Maudlin
6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 10, 1867
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 69 7 28
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Iowa

10. NAME OF FATHER James Maudlin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY) Not known
12. MAIDEN NAME OF MOTHER Esther Maudlin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
(STATE OR COUNTRY) Not known

14. INFORMANT John Maudlin
(Address) Frank City, Mo.

15. FILED 2/10/32 John Maudlin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4, 1932
17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____, that I last saw him alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis
arterio sclerosis
age

CONTRIBUTORY (SECONDARY) age
(duration) yrs. mos. ds. 1

18. WHERE WAS DISEASE CONTRACTED Don't know
IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) O. L. Sullivan, M. D.
(Address) 1032 E. Cherry St. Iowa

*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 Nichols Grove
DATE OF BURIAL 1-6-32

20. UNDERTAKER Rhodes
ADDRESS Wt. Ave

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

FEB 25 1932

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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Worth
Township Smith
City Newton (No. 1)

Registration District No. 903
Primary Registration District No. 6211

File No. 3585
Registered No. 7 St. Ward

2. FULL NAME

Newton M. Mandlin

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 3 - 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 8 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 5-10 1932 John Andrews Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1 1932

22. I HEREBY CERTIFY That I attended deceased from to , 19

I last saw him alive on , 19 . Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Hypertrophy of heart
arteriosclerosis
basels
Primary
Myocardial
Infarction

Other contributory causes of importance:
46

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) , M. D.

(Address)

S-3584