

Registration District No.

577

Primary Registration District No.

3029

Registrar's No.

174

## 1. PLACE OF DEATH:

(a) County Marion  
 (b) City or town Hannibal  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Levering  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 9 Days  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Daniel Marion Maupin 150

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Sarah Jane Clark Maupin 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased July 31, 1846  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
93 10 8 hr. min.9. Birthplace Hannibal Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Charles Morris Maupin13. Birthplace Virginia  
(City, town, or county) (State or foreign country)14. Maiden name Elizabeth Barton15. Birthplace Virginia  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature J W Maupin(b) Address 715 Ben Lomond17. (a) Burial (b) Date thereof 6/11/40  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Oak Ridge Missouri18. (a) Signature of funeral director Frank W. Smith(b) Address 902 Broadway Hannibal19. (a) 6/30/40 (b) St. C. Tucker  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion  
 (c) City or town Hannibal  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 715 Ben Lomond  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8  
year 1940 hour 11 minute 55P. M.21. I hereby certify that I attended the deceased from May 30 - 40  
1940, to June 8, 1940  
that I last saw him alive on June 8, 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Fractured Femur Duration  
(Lower fracture)Due to Fall

Due to \_\_\_\_\_

Other conditions Senility  
(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?  
Yes

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. B. Blue (M. D. or other) \_\_\_\_\_Address Hannibal Mo Date signed \_\_\_\_\_

144/10

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**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Joseph J. Martin*

Licensed Embalmer No. **3932**

P. O. Address **Hannibal Missouri**

**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 this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22249

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 547

Primary Registration District No. 3029

Registrar's No.

1. PLACE OF DEATH:

(a) County. Massion  
(b) City or town. Wasson  
(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.  
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Daniel Marion Maufer  
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.  
93 10 8

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

12. Name.

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name.

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant. (b) Address.

17. (a) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director. (b) Address.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County.  
(c) City or town. (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.

20. DATE OF DEATH. Month June day 8  
year 1940 hour. minute. M.

21. I hereby certify that I attended the deceased from 19. to 19. that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death fractured femur

Due to Fall! Don't know  
was not there

Other conditions leukemia  
(Include pregnancy within 3 months of death)

Major findings: Of operations. 6/8  
10/11

Of autopsy.

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? While at work? (Specify type of place) (e) Means of injury. Fall!

23. Signature (M. D. or other) Address Date signed

SUPPLEMENTARY

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

