S. No. 2
M—5-42
v. 5-17-39
I X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 7 1945

Registration District No. 7

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5064

State File No. 12746

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Barton LeRoy Twp

(b) City or town Arcadia, Kan RR#1
(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 (Specify whether
In this community 63 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Barton

(c) City or town Arcadia, Kan RR#1
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Reuben S. Mapes

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 Married

6. (b) Name of husband or wife Sarah

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased March (Month) 24 (Day) 1861 (Year)

8. AGE:

Years	Months	Days	If less than one day
84	0	21	hr. min.

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

10. Usual occupation Retired Carpenter

11. Industry or business

FATHER
12. Name Benjamin Mapes
13. Birthplace Ind (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Adeline Snidley
15. Birthplace Ind (City, town, or county) (State or foreign country)

16. (a) Informant William Roy Mapes
(b) Address Arcadia, Kans

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 (Month) 17 (Day) 1945 (Year)
(c) Place: burial or cremation Leroy Cemetery

18. (a) Signature of funeral director S. F. Moonshan
(b) Address Arcadia, Kans

19. (a) Apr. 20-1945 (Date received local registrar) (b) Blanche Sackett (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15 year 1945 hour 6 am minute M.

21. I hereby certify that I attended the deceased from 4/2, 1945, to 4/14, 1945; that I last saw him alive on 4/2, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pernicious Anemia	
Due to 0	
Due to 0	
Other conditions Senility (Include pregnancy within 3 months of death)	
Major findings: Of operations Rapid fall in % age of hemaglobin	
Of autopsy 0	

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) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0 (Specify type of place)

While at work? 0 (e) Means of injury 0

23. Signature A. G. Eidleman (M. D. or other)

Address Liberal Mo. Date signed 4/17/45

(Licensed Embalmer's Statement on Reverse Side)

JAN 27 1948
RECEIVED
District Health Officer No. 6
District File Number 545-516
Date Filed MAY 4 1945

MAR 1 1946

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 me, Registered Apprentice No. , working under my personal supervision.

Signed N. T. Moonehan

Licensed Embalmer No. 3616

P. O. Address Arcadia, Kans.

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, fact should be so stated above.