

No. 2  
12-45  
17-36  
47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36436  
Registrar's No. 47

FILED NOV 22 1946

Registration District No. 77

Primary Registration District No. 4136

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

1. PLACE OF DEATH:  
(a) County CLINTON  
(b) City or town Plattsburg  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 70 yrs.  
In this community 70 yrs.  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Clinton  
(c) City or town Plattsburg  
(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 Louella MAUPIN  
(b) If veteran, name war no  
(c) Social Security No. NONE

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 5  
year 1946 hour 6 minute 10 P.M.  
21. I hereby certify that I attended the deceased from Nov 1, 1946, to Nov. 5, 1946  
that I last saw her alive on Nov 1, 1946,  
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race w  
6. (a) Single, widowed, married, divorced single  
(b) Name of husband or wife \_\_\_\_\_ (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct. 27 1870  
(Month) (Day) (Year)

Immediate cause of death Coronary occlusion Duration 10 min.

8. AGE: Years 76 Months 0 Days 8  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Acute Gastritis 5 dr.  
(Include pregnancy within 3 months of death)

9. Birthplace Clinton County Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation housekeeper

Major findings: Of operations none  
Of autopsy none  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name William Maupin  
13. Birthplace Tenn  
(City, town, or county) (State or foreign country)  
14. Maiden name Amanda Harris  
15. Birthplace Clinton County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Colna Kincaid  
(b) Address Plattsburg Mo.  
17. (a) Burial (b) Date thereof 11/7/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Lethrop Mo.  
18. (a) Signature of funeral director Lyon Funeral Home  
(b) Address Plattsburg Mo.  
19. (a) Nov 4-46 (b) John A. Martin  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_  
23. Signature W. B. Spalding (M. D. or other) MD  
Address Plattsburg Mo. Date signed Nov 6-46

65 (Licensed Embalmer's Statement on Reverse Side)

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

---

---

**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 *Danell D. Lyon*

Licensed Embalmer No. 3640

P. O. Address *Platteburg mo*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1111  
Registrar's No. 47

Registration District No. 74

Primary Registration District No. 4136

1. PLACE OF DEATH: Clinton  
(a) County Clinton  
(b) City or town Plattsburg  
(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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Laurelle Maurin  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 27 (Month) (Day) (Year)

8. AGE: Years 26 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation house keeper

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

MOTHER FATHER { 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) \_\_\_\_\_ (Burial, cremation, or removal) (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) Gas L Martin (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov Day 15 Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

SUPPLEMENTARY

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

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

143880

36436