

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30074**

FILED OCT 8 - 1955

BIRTH NO. _____ REG. DIST. NO. **175** PRIMARY REG. DIST. NO. **3036** Registrar's No. **82**

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Aurora		c. CITY OR TOWN Aurora	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 121 West High St.		• STREET ADDRESS (If rural, give location) 121 W High 055/0	

3. NAME OF DECEASED (Type or Print) a. (First) Ahies	b. (Middle) S. MAPLES	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) SEPT-6-1955
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC-10-1873	9. AGE (In years last birthday) 81	UNDER 1 YEAR Months Days	IF UNDER 18 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (City and State or Foreign Country) Christian County	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William Maples	13b. MOTHER'S MAIDEN NAME MARtha MAPLES	14. NAME OF HUSBAND OR WIFE GRACE MAPLES
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Ward Maples	ADDRESS Marionville Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metabolic Kelanoma -		INTERVAL BETWEEN ONSET AND DEATH 2 years.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Primary - 4th toe		
	DUE TO (c) st. foot.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 190X			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **1938** to **9-6**, 19**55**, that I last saw the deceased alive on **9-2**, 19**55**, and that death occurred at **12:30 PM**, from the causes and on the date stated above.

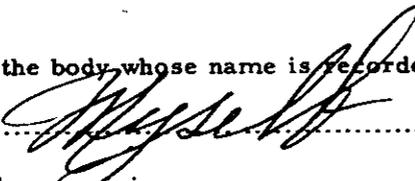
23a. SIGNATURE A. P. Cooper (Degree or title) M.D.	23b. ADDRESS Aurora, Mo.	23c. DATE SIGNED Sept. 7, 1955
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/8/55	24c. NAME OF CEMETERY OR CREMATORY Frazier Cemetery	24d. LOCATION (City, town, or county) (State) Clever, MO.
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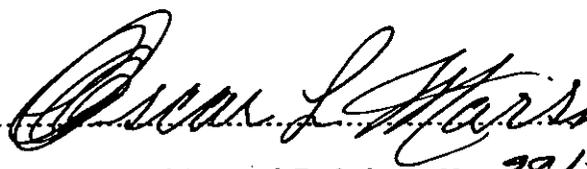
DATE REC'D BY LOCAL REG. 10-4-55	REGISTRAR'S SIGNATURE Ora Mc Natt	25. FUNERAL DIRECTOR'S SIGNATURE William Stark ADDRESS Aurora, Mo.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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  Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 381

P. O. Address 

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.