

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40465

FILED JAN 8 1957

STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. 5020 Registrar's No. 1

|  |                                  |   |  |   |  |
|--|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ATCHISON</u>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>IOWA</u> b. COUNTY <u>FREMONT</u> |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>BUCHANAN</u>   |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | c. CITY OR TOWN <u>HAMBURG</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>RURAL</u>  |                                  | Length of stay in lb<br><u>1 hr</u>   | d. STREET ADDRESS (If outside, give location)<br><u>1605 PARK ST.</u>  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>OLIN</u> Middle <u>BIARD</u> Last <u>MAUPIN</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>30</u> Year <u>1956</u>   |   |  |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>NOV 3, 1885</u>   | 9. AGE (In years last birthday) <u>71</u><br>IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>27</u> Hours <u></u> Min. <u></u><br>IF UNDER 24 HRS. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED FARMER</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><u>ATCHISON CTY. MO.</u>  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |
| 13. FATHER'S NAME<br><u>EDWIN MAUPIN</u>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>MOLLIE RHOADES.</u>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>85-2046627</u>  |  | 17. INFORMANT<br>Address <u>Hamburg Iowa</u><br><u>Harold E. Clappil</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u>                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |
| 20c. TIME OF INJURY<br>Hour _____ a. m. _____ p. m. _____  |                                  |   |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 20f. CITY, TOWN, OR LOCATION<br>COUNTY _____ STATE _____  |  |
| 21. I attended the deceased from <u>Sept - 1956, to Nov 21 52</u> and last saw her alive on <u>Dec 20 52</u><br>Death occurred at <u>12:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Walter</u>  |                                  | 22b. ADDRESS<br><u>Hamburg Iowa</u>   |  | 22c. DATE SIGNED  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Jan 2-1957</u>   |                                  | 23b. DATE<br><u>Jan 2-1957</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St Olive</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>Paul C. Johnson</u>   |                                  | ADDRESS<br><u>Hamburg Iowa</u>  |  | 25. DATE RECD. BY LOCAL REG.<br><u>Jan 3, 1957</u>  |  |
|  |                                  |   |  | 26. REGISTRAR'S SIGNATURE<br><u>Theroin H. Schoeler</u>   |  |

Health, Welfare, Public Service  
000-56  
Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms with reference to natural causes. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

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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 myself....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Chas. C. Johnson.....

Licensed Embalmer No. 283

P. O. Address Hanbury

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.