THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

58-016657
STATE FILE NUMBER

FILED APR 28 1958

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 1114

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): University City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Christian Old Peoples Home — Length of stay in Ib: 2 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Jennings 4150 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 7075 Lillian Avenue. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First / Middle / Last: MAGGIE M. MAUPIN

4. DATE OF DEATH: Month / Day / Year: April 19, 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH: Feby 8, 1873
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Jefferson Co. Missouri.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: James Williams
13b. MOTHER'S MAIDEN NAME: Ary Jane Graham
14. NAME OF HUSBAND OR WIFE: Edward Maupin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Address: Mrs Mary Boone, 3517 St. Gregory Lane.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mitral Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Senility.
DUE TO (c): 410X
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? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION / COUNTY / STATE

21. I attended the deceased from Sept. 1957, to Apr. 19-58 and last saw her/him alive on April 17, 58
Death occurred at 8:50 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: T. Rhyars M.D. (Degree or title)
22b. ADDRESS: 607 N. Grand
22c. DATE SIGNED: 4-21.58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: April 23, 1958
23c. NAME OF CEMETERY OR CREMATORY: Masonic Cemetery
23d. LOCATION (City, town, or county) (State): Blackwell, Missouri

24. FUNERAL DIRECTOR / ADDRESS: Shepard Funeral Home 1167 Hamilton Ave
25. DATE RECD. BY LOCAL REG.: 4-22-58
26. REGISTRAR'S SIGNATURE: Herbert R. Donke M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 John L. Denner

Licensed Embalmer No. 4194

P. O. Address St. Louis

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.