

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026142
STATE FILE NUMBER

FILED JUL 22 1958 Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 77

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, give TOWNSHIP only) OR TOWN Aurora		c. CITY OR TOWN Aurora 0540	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Aurora Hospital		d. STREET ADDRESS (If outside, give location) 141 W. Tyndall St.	
3. NAME OF DECEASED (Type or print) First Leslie Middle L. Last Maples		4. DATE OF DEATH Month July Day 16 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1894
10a. USUAL OCCUPATION (Give kind of work done during past working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (City and state or country) Christian Co. Mo.		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Timothy Maples		13b. MOTHER'S MAIDEN NAME Manvera Fraizer	
14. NAME OF HUSBAND OR WIFE Stella Maples		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. _____		17. INFORMANT Stella Maples Address Aurora, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure			INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic lung disease			
DUE TO (c) _____			
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 <input type="checkbox"/> NO <input checked="" 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 Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE	
21. I attended the deceased from 7/7/58 to 7/16/58 and last saw her ^{alive} on 7/16/58 Death occurred at ca. 6 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J.A. Morrison M.D.		22b. ADDRESS Aurora, Mo.	
22c. DATE SIGNED 7/17/58		23a. NAME OF CEMETERY OR CREMATORY Manley Cemetery	
23b. DATE 7/19/58		23d. LOCATION (City, town, or county) (State) Brookline, Missouri.	
24. FUNERAL DIRECTOR Marsh Funeral Service, Aurora, Mo.		25. DATE RECD. BY LOCAL REG. 7/17/1958	
26. REGISTRAR'S SIGNATURE Ora Mc Natt			

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ray E. Ireland*

Licensed Embalmer No. *5057*

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