

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 2 1959

59-031821

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 264

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1. PLACE OF DEATH a. COUNTY <u>Cole</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Jefferson City</u>		Length of stay in 1b		c. CITY OR TOWN <u>Carrollton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Governor Hotel</u> <u>200 Madison</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>217 North Monroe Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>WADE WILLIAM MAUPIN</u>				4. DATE OF DEATH Month Day Year <u>September 29, 1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-8-1901</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>21</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Attorney</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>		11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Dolph A. Maupin</u>			13b. MOTHER'S MAIDEN NAME <u>Molly Wade</u>			14. NAME OF HUSBAND OR WIFE <u>Leotta Huff Maupin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>497-36-3349</u>		17. INFORMANT <u>Mrs. Leotta Maupin</u>			Address <u>217 N. Monroe Street</u> <u>Carrollton, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Embolism</u> <u>infection</u> DUE TO (b) <u>Coronary thrombosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>7 min.</u> <u>3 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 <u></u> s.m. <u></u> p.m. <u></u>		Month, Day, Year							
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		COUNTY		STATE	
21. I attended the deceased from <u>9-29-59</u> to <u>9-29-59</u> and last saw <u>her</u> alive on <u>9-29-59</u>				Death occurred at <u>9:30 A. M.</u> <u>home</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>D. P. Denton D.O.</u>				22b. ADDRESS <u>Charleston, Mo</u>		22c. DATE SIGNED <u>9/29/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem. & Burial</u>		23b. DATE <u>Oct 2 - 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carrollton Cemetery</u>		23d. LOCATION (City, town, or county) <u>Carrollton, Mo.</u>			(State)	
24. FUNERAL DIRECTOR'S ADDRESS <u>Victor Buescher</u>				25. DATE RECD. BY LOCAL REG. <u>29 Sept. 1959</u>		26. REGISTRAR'S SIGNATURE <u>R.P. Davis, MD - Wright</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS OCT 7 1959

FEB 28 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Victor Buesch

Licensed Embalmer No. 370

P. O. Address Jcm

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.