

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002978

FILED VS JAN 20 1960 301

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 4

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Ripley</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Ripley</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>DONIPHAN</b>		Length of stay in 1b <b>3 Hours</b>	c. CITY OR TOWN <b>DONIPHAN</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Community Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>RFD # 6</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Aden</b> Middle <b>Maples</b> Last <b>Maples</b>			4. DATE OF DEATH Month <b>JAN.</b> Day <b>7</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1911</b>	9. AGE (last birthday) <b>48</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>	11. BIRTH PLACE (City and state or country) <b>Ripley County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Limuel Maples</b>	13b. MOTHER'S MAIDEN NAME <b>LONIA Russell</b>	14. NAME OF HUSBAND OR WIFE <b>Robert Maples</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>Robert Maples</b>	Address <b>R#6 Doniphan Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerotic heart disease</b>	
	DUE TO (c) _____	

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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ 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 _____
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21. I attended the deceased from **June 57** to **Jan 7, 1960** and last saw <sup>her</sup> ~~him~~ alive on **Jan 7, 1960**  
Death occurred at **5:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Frank Johnson</b> (Degree or title) <b>MD</b>	22b. ADDRESS <b>Doniphan Mo.</b>	22c. DATE SIGNED <b>1/11/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JAN. 9, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>POYNOR Cemetery</b>	23d. LOCATION (City, town, or county) <b>POYNOR MISSOURI</b>
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24. FUNERAL DIRECTOR <b>Edwards Funeral Home Doniphan, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>1-12-1960</b>	26. REGISTRAR'S SIGNATURE <b>Flava Bray</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Gene Harvett

Licensed Embalmer No. 4809  
P. O. Address Naylor, W

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.