

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007061

FILED VS FEB 23 1960

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 20

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Lawrence County		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		Length of stay in 1b 24 hrs	c. CITY OR TOWN Marionville Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Aurora Community Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Center Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Thomas Middle Franklin Last Maples			4. DATE OF DEATH Month February Day 11 Year 1960		
5. SEX Male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1879	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursery work		10b. KIND OF BUSINESS OR INDUSTRY Orchard Nursery	11. BIRTHPLACE (City and state or country) Boaz, Missouri	12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Gideon Maples		13b. MOTHER'S MAIDEN NAME Sarah Wilson		14. NAME OF HUSBAND OR WIFE Nealie Finney Maples	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 500-01-6738	17. INFORMANT Address Nellie Bennage, Marionville, Mo.		

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>Bronchopneumonia, RUL</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <u>Influenza</u>		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 checked="" 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. 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 4 AM 2/10/60 to death and last saw her alive on 2/11/60
Death occurred at 3:00 a. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. B. Swidger M.D.</u>		22b. ADDRESS <u>Aurora Mo.</u>		22c. DATE SIGNED <u>2/13/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 13, 1960	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	23d. LOCATION (City, town, or county) (State) Marionville, Missouri.	
24. FUNERAL DIRECTOR <u>J. B. Swidger</u> ADDRESS Marionville, Mo.		25. DATE RECD. BY LOCAL REG. <u>2-14-1960</u>	26. REGISTRAR'S SIGNATURE <u>Ora Mc Natt</u>	

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 William A. Fuller

Licensed Embalmer No. 4658

P. O. Address Marionville

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.