

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020108

STATE FILE NUMBER

FILED MAY 26 1959

Registration District No. 337 Primary Registration District No. 4499 Registrar's No. 50

S. 300  
P. 1-57

1. PLACE OF DEATH a. COUNTY <b>Shelby</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Shelby</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Shelbina</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Shelbina, Mo. Rural</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		Length of stay in 1b <b>6 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>8 Miles Sw. Shelbina, Mo.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Samuel Rice Maupin</b>			4. DATE OF DEATH Month <b>5</b> Day <b>13</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-4-1864</b>
9. AGE (In years last birthday) <b>94</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Shelby Co., Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>A. B. Maupin</b>	13b. MOTHER'S MAIDEN NAME <b>Salina Miller</b>
14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>X</b>
17. INFORMANT <b>Mrs. Jean Margaret Timbrook</b>		Address <b>Clarence, Mo.</b>	
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>Acute coronary occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary atherosclerosis.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>			INTEGRAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>25 years</b>
19. WAS AUTOPSY PERFORMED? <b>2</b> 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 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>Feb 1956</u> to <u>present</u> and last saw him alive on <u>May 13, 1958</u> Death occurred at <u>11: A. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Oliver A. Priddy MD</i>		22b. ADDRESS <b>Shelbina Mo.</b>	
22c. DATE SIGNED <b>5/18/59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>5-15-1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F.</b>	
23d. LOCATION (City, town, or county) <b>Shelbina, Missouri</b>		23e. STATE <b>Missouri</b>	
24. FUNERAL DIRECTOR <b>Barkelaw &amp; Davis Shelbina, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>May 21-59</b>	
26. REGISTRAR'S SIGNATURE <i>Ada Garrison</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Henry A. Barkelou*

Licensed Embalmer No. *3835*

P. O. Address *Shelburne Vt*

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.