LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

Dr N. C. Williams

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Greene

Hinton Bldg.

Township ..... Registration District No. 318 File No. 45517

or

Village ..... Primary Registration District No. 2001 Registered No. 968

or

City Springfield Mo (No. St. John's Hospital St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Alexander Maxwell.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: July (Month) 11 (Day), 1877 (Year)

7 AGE: 41 yrs. 5 mos. 14 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Sales Manager
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country): Boston Mass.

PARENTS

10 NAME OF FATHER: Audley Maxwell

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Georgia

12 MAIDEN NAME OF MOTHER: Catherine Cameron

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): New Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A. Maxwell

(Address) Drumwright Okla

15 Filed DEC 26 1918, 191 Edwin F. James Dallie B. Johnson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 2 Dec (Month) 25 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 24, 1918, to Dec 25, 1918, that I last saw him alive on Dec 25 6 PM, 1918, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

11A Pneumonia Broncho

10

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

8 (Duration) ....yrs. ....mos. ....ds.

(Signed) N C Williams M. D.

Dec 26, 1918 (Address) 318 College St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: East Lawn

DATE OF BURIAL: Dec 27, 1918

20 UNDERTAKER: Lohmeyer Und Co

ADDRESS: 305 N Walnut

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1..... (Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country) .....

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

..... 191..... to ..... 191.....,

that I last saw h.....alive on ..... 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 191.....
20 UNDERTAKER	ADDRESS

V. S. No. 2. A

MARGIN RESERVED FOR BINDING

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