

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

Do not use this space.

37129

1. PLACE OF DEATH

County Jefferson
Township Blue
City Leeds

Registration District No. 399
Primary Registration District No. Leeds Hospital

File No. _____
Registered No. 4780
St. _____ Ward _____

2. FULL NAME

Sherman Maxwell
(a) Residence. No. 3931 E. 13th -- St. 13 Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 47 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Della Maxwell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July - 22 1865

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	63	4	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer Holf's Laundry

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER John Maxwell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) England

12. MAIDEN NAME OF MOTHER Margaret Thompson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Pennsylvania

14. INFORMANT K.C.B. Hospital
(Address) Leeds Mo

15. FILED 11/27 1928 M. M. Corvett
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11 - 27 1928

17. I HEREBY CERTIFY, That I attended deceased from 12 - 29 1927, to 11 - 27 1928 that I last saw alive on 11 - 26 1928, and that death occurred, on the date stated above, at 12:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
(duration) _____ yrs. mos. da.
CONTRIBUTORY (SECONDARY) 31
(duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Microscopical
(Signed) Beane C. Gode, M. D.

11/27 1928 (Address) 1002 Angles Rd. K.O. Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Elmwood DATE OF BURIAL 11-28-28
20. UNDERTAKER Mrs. C.L. Foster ADDRESS 918 Brooklyn

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.

RECORD

Argyle Sdg.