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

Do not use this space.

34345

File No. .....
Registered No. 105

1. PLACE OF DEATH
County Livingston ..... Registration District No. 508
Township ..... Primary Registration District No. 3026
City Chillicothe ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Betty R. Maxwell.
(a) Residence. No. 412 Walnut St., 4 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 30-1859.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	2	11	

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Callao Mo.

PARENTS
10. NAME OF FATHER Monet H. Smith.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Shelby Co. Mo.
12. MAIDEN NAME OF MOTHER Margaret Shelton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Lincoln Co. Tenn.

14. INFORMANT Mr. J. W. Maxwell.
(Address) Chillicothe, Mo.

15. FILED 10/11, 1929 Reuben Barney
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. - 11 - 1929.

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 24, 1924 to Oct. 11th, 1929, that I last saw her alive on Oct 11, 1929, and that death occurred, on the date stated above, at 11:10 - a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastric Carcinoma.
4 M B
GHO
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) .....
(duration) yrs. mos. ds.

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? none.
(Signed) F. H. Emmons, M. D.
Oct 11, 1929. (Address) Chillicothe 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 Edgewood Cem. — DATE OF BURIAL Oct. 12, 1929
20. UNDERTAKER James D. Gordon. — ADDRESS Chillicothe Mo.

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.