

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

Do not use this space.

1. PLACE OF DEATH

County *Bates*

Township *Pleasant Gap*

City

(No.)

Registration District No. *58*

Primary Registration District No. *5092*

File No. *32062*

Registered No. *56*

St.

Ward)

2. FULL NAME

Maudana D Maxwell

(a) Residence. No.

St.

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

female

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

H. L. Maxwell

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Feb 11, 1862

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

68

7

22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Illinois

(STATE OR COUNTRY)

10. NAME OF FATHER

Wm. Daniels

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Ill.

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Ellen Mitchell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Ohio

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

*H. L. Maxwell
Butte, Mo.*

15.

FILED

10/15 1930

J. H. Reimpton

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *October 15 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 27*, 19*30*, to *Oct 15*, 19*30* that I last saw him alive on *Oct 15*, 19*30*, and that death occurred, on the date stated above, at *9:30* *P.*m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of head of pancreas.

H10F (duration) yrs. *3* mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH *No.* DATE OF

20. WAS THERE AN AUTOPSY? *No.*

21. WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *L. E. H. Thiele*, M. D.

10/16 1930 (Address) *Butte, 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

DATE OF BURIAL

Out Hill

Oct 17, 1930

20. UNDERTAKER

ADDRESS

Edwards

Butte, 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.

NOV 21 1930

10/12 30 P.M. 1900

1/13/00

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