

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

JAN. 20 1936

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

*Wm. K. Brown*  
ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.  
File No. **340778**  
Registered No. **50**

1. PLACE OF DEATH  
County *St. Charles* Registration District No. *760*  
Township *Dardenne* Primary Registration District No. *6701*  
City (No. St. Ward)  
2. FULL NAME *"Infant" Maxwell*  
(a) Residence, No. St. Ward. (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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Dec 4 - 1935</i>		
7. AGE YEARS <input checked="" type="checkbox"/>	MONTHS <input checked="" type="checkbox"/>	DAYS <i>3</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		<input checked="" type="checkbox"/>
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		<input checked="" type="checkbox"/>
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Charles County</i>		
13. NAME <i>Jesse Maxwell</i>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Sibley, Mo</i>		
15. MAIDEN NAME <i>Viola Frances Bass</i>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS) <i>Jesse Maxwell</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Oak Grove Cem</i> DATE <i>Dec 7</i> , 1935		
19. UNDERTAKER (ADDRESS) <i>W.C. Allmyer &amp; Sons Co St. Charles Mo</i>		
20. FILED <i>12/13</i> , 1935 <i>W.C. Caldwell</i> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 7*, 1935

22. I HEREBY CERTIFY, That I attended deceased from *Dec 4*, 1935, to *Dec 7*, 1935  
I last saw him alive on *Dec 7*, 1935. Death is said to have occurred on the date stated above, at *3 1/2* m.  
The principal cause of death and related causes of importance were as follows:  
*Premature Infant (7 1/2 months) (Spontaneous delivery)*  
Other contributory causes of importance:  
*None*

Name of operation *None* Date of \_\_\_\_\_  
What test confirmed diagnosis *Placental* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? *no*  
If so, specify \_\_\_\_\_ (Signed) *Wm. K. Brown*, M. D.  
(Address) *2001 Locust St. Charles, Mo.*

