

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

Do not use this space.

1. PLACE OF DEATH **MAY 31 1937**  
 County St. Louis Registration District No. 1123  
 Township Crossedix Primary Registration District No. 6248B  
 City Kenn. Mo. (No. Roch. Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 File No. 17627  
 Registered No. 184

2. FULL NAME Basel Maxwell  
 (a) Residence, No. 4306 Cate Building Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred: 15 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male  
 4. COLOR OR RACE Negro  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-27-21  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
15 7 0

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Teacher  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) Sept 4, 1929  
 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Tenn  
 13. NAME Basel Maxwell  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Tenn

MOTHER FATHER  
 15. MAIDEN NAME Lillian ?  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Tenn

17. INFORMANT Local Hospital Records  
 (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Washington Pk. DATE May 1 1937

19. UNDERTAKER A. D. Richardson  
 (ADDRESS) 2600 N. Leffingwell  
 20. FILED Apr 30 1937 S. Mowrey  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-27-37 1937  
 22. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1936 to Apr 27 - 1937, 1937.  
 I last saw him alive on 4-27-37, 1937. Death in said to have occurred on the date stated above, at 12:45 p.m.  
 The principal cause of death and related causes of importance were as follows:

Influenza  
 Date of onset 1929  
 Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1937  
 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) R. K. Robinson, M. D.  
 (Address) Robert Keel Dupike

Exact statement of OCCUPATION is very important.

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FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

17627  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 1123  
(b) Township Carondelet Primary Registration District No. 6248 G Registered No. 184  
(c) City ..... (d) Street No. .... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Booker Maxwell

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
18 7 0

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
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)

FATHER  
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 92 Meyer M. D. P. H. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-27 1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive ..... 19..... Death is said

to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Tuberculosis of Spine  
Skull Bones

Date of onset

1929  
1939

Other contributory causes of importance: 76

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....

If so, specify.....

(Signed) C. G. Robinson M. D.

(Address) West Hill Hosp

SUPPLEMENTARY

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

5-17627