

RECORDED AUG 7 1939

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

24851  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township 1st Primary Registration District No. 1002 Registered No. 3064  
 (c) City W. C. Mo! (d) Street No. W. C. Sun Hosp 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 Robert E. Maxwell  
 (a) Residence, No. 6503 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 W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 20 - 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
82 7 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

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) Ky. 1

13. NAME no Record

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no Record

15. MAIDEN NAME Sarah Martin

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no Record

17. INFORMANT (ADDRESS) Record Clerk W. C. Sun Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenlawn DATE 7-31-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Phillip General Burial Indip Ave

20. FILED 7-31-39 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-29-39 19

22. I HEREBY CERTIFY, That I attended deceased from 7-22-39 19, to 7-29-39 19, I last saw him alive on 7-27-39 19. Death is said to have occurred on the date stated above, at 1:30 p. m. The principal cause of death and related causes of importance were as follows:  
Intertrochanteric fracture of femur  
accidental fall at home  
 Other contributory causes of importance:  
Acute Pulmonary edema and congestive heart failure

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? acc. Date of injury 7-22-39 Where did injury occur? home (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall  
 Nature of injury Fracture femur

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_ (Specify) \_\_\_\_\_ (Signed) O. J. DeMarco M. D. (Address) Supt. W. C. Sun Hosp

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.

WHILE YOUNG, WITH OUTSTANDING RECORD—THIS IS A PERMANENT RECORD

I X14028

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_

or by

*JOE B. Yoder*

Registered Apprentice No. \_\_\_\_\_

*# 233*

working under my personal supervision.

Signed \_\_\_\_\_

*John P. Sheel*

Licensed Embalmer No. \_\_\_\_\_

*# 3625*

P. O. Address \_\_\_\_\_

*6606 Ind. Ave.  
R. C. Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**