

NOV 13 1939 791

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **8427**

1. PLACE OF DEATH: **1003** **2**
 (a) County _____
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2425 S. 9th St.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community **50 Years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **1**
 (c) City or town **St. Louis** **23**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2425 S. 9th St.**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME **Lena Maxon** **250**
 3. (b) If veteran, name war **---** 3. (c) Social Security No. **---**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Charles Maxon** 6. (c) Age of husband or wife if alive **65** years
 7. Birth date of deceased **Sept. 3, 1872**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	0	29	_____ hr. _____ min.

9. Birthplace **Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Home**

11. Industry or business _____

12. Name **Joseph Barrow**

13. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Laura Smith**

15. Birthplace **Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Charles J. Maxon**
 (b) Address **2425 S. 9th St.**

17. (a) **Burial** (b) Date thereof **10/4/39**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **N. St. Marous**

18. (a) Signature of funeral director **Wacker - Weldon**
 (b) Address **2331 S. Broadway**

19. (a) **OCT 2 1939** (b) **J. J. Budick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **1**
 year **1939** hour **10** minute **12 p. M.**

21. I hereby certify that I attended the deceased from **9-3-39**, 19____, to **10-1-**, 19**39**
 that I last saw **her** alive on **9-30-**, 19**39**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Anuria - uremia**
 Duration **8 day**

Due to **Chr. interstitial nephritis**
Carcinoma of uterus
 Due to **Chr. myocarditis**
Mitral regurgitation

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **HO**
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (a) Means of injury _____

23. Signature **W. R. Gunn** (M. D. or other) _____
 Address **2227 S. Broadway** Date signed **10-4-39**

PHYSICIAN

 Underline the cause to which death should be charged statistically

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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.....

Robert C. White

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Robert C. White

Licensed Embalmer No. *2128*

P. O. Address. *St. Louis*

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.