DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

DEC 11 1939 38424

State File No.

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4188

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K C Gen Hospt (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 days (Specify whether years, months or days) In this community 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 2414 Chestnut (If rural, give location)
(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Anna Maxwell
3. (b) If veteran, name war No.
3. (c) Social Security No. No
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Joseph F. Maxwell
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased March (Month) 12 (Day) 1879 (Year)

8. AGE: Years	Months	Days	If less than one day
60	7	19	hr. min.

9. Birthplace (City, town, or county) Ill (State or foreign country)
10. Usual occupation Housewife
11. Industry or business ---------
FATHER
12. Name No Record
13. Birthplace Illinois (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name No Record. Shoemaker
15. Birthplace Illinois (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Record Clerk
(b) Address K C Gen Hospt
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2 (Month) (Day) 39 (Year)
(c) Place: burial or cremation Memorial Park Cemetery.
18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address 918 Brooklyn K.C.Mo.
19. (a) Nov. 1, 1939 (Date received local registrar) (b) Mr. M. Orome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31 year 1939 hour 12 minute 30-a M.
21. I hereby certify that I attended the deceased from Oct 5, 1939, to Oct 31, 1939 that I last saw her alive on Oct 31-39, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death P.O. Cholecystojejunostomy	
Due to Carcinoma of pancreas and ampulla Vater	
Due to Primary Head of Pancreas	1/6
Other conditions (Include pregnancy within 3 months of death) Hypostatic congestion of lungs	
Major findings: Of operations See above	
Of autopsy See above	

PHYSICIAN — Underline the cause to which death should be charged statistically

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature C F De Maria MD (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.

Rev. 5-17-39 I X19511

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed David C. Browning

Licensed Embalmer No. 2724

P. O. Address K. 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.