DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41658

Registrar's No. 10781

Registration District No. 1791 1003 JAN 16 1940

Primary Registration District No.

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Mo. 1
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days. (Specify whether years, months or days)
In this community Same.

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town San Antonio NR
(If outside city or town limits, write "RURAL")
(d) Street No. 2107 West Mistletoe
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME ALEXANDER C. MAXWELL 211
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex MALE
5. Color or race White
6. (a) Single, widowed, married, divorced Marr.
6. (b) Name of husband or wife MRS. Sadie Maxwell
6. (c) Age of husband or wife if alive unk years
7. Birth date of deceased June (Month) 12 (Day) 1897 (Year)

8. AGE: Years 42 Months 6 Days 4 If less than one day hr. min.

9. Birthplace Austin (City, town, or county) Texas (State or foreign country)
10. Usual occupation Retired
11. Industry or business Electrical Engineer
FATHER 12. Name William Maxwell
13. Birthplace Virginia (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Florence Garrett
15. Birthplace Virginia (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Mrs. Sadie Maxwell
(b) Address San Antonio, Texas
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 12-18-39 (Month) (Day) (Year)
(c) Place: burial or cremation San Antonio, Texas
18. (a) Signature of funeral director Albert H. Hoppe Inc.
(b) Address 4700 Washington Blvd.
19. (a) DEC 18 1939 (Date received local registrar) (b) J. F. Budsch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16 year 1939 hour 6 minute 55 A. M.
21. I hereby certify that I attended the deceased from Dec 1, 1939, to Dec 16, 1939; that I last saw him alive on Dec. 15, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Post-operative hemorrhage following Cranotomy for	2 days
Due to Paralysis Agitans	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Intra-cranial hemorrhage Bronchopneumonia

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 Cecil G. Aker (M.D. or other) M.D.
Address St. Lukes Hosp. St Louis Date signed 12/16/39

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.

(Licensed Embalmer's Statement on Reverse Side)

10781

10781

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 J. G. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

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

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