

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

7965  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County St. Clair Registration District No. 761  
 (b) Township Appleton Primary Registration District No. 445p  
 (c) City Appleton (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.

Registered No. 7

**2. PRINT FULL NAME**

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May, 24, 1892</u>		
7. AGE YEARS <u>47</u>	MONTHS <u>8</u>	DAYS <u>2</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>School Teacher</u>		
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) <u>Irish, Mo.</u>		
FATHER	13. NAME <u>Wm F. Maxwell</u>	
FATHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tenn</u>	
MOTHER	15. MAIDEN NAME <u>Cardelia M. Simons</u>	
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>New York</u>	
17. INFORMANT (ADDRESS) <u>Nellie M. Maxwell Appleton City, Missouri</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Appleton City</u> DATE <u>Feb 1</u> 19 <u>40</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Brian Eckhoff Appleton City, Mo.</u>		
20. FILED <u>Feb 1</u> 19 <u>40</u> <u>Chas. Abrey</u> Local Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 30 1940

22. I HEREBY CERTIFY, that I attended deceased from July June 1939 to Jan 30 1940  
 last saw him alive on Jan 30 1940 Death is said to have occurred on the date stated above, at 7 P. m.  
 The principal cause of death and related causes of importance were as follows:

Cancer of breast  
and metastasis  
50

Other contributory causes of importance:  
Cholelithiasis

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? no  
 If so, specify \_\_\_\_\_  
 (Signed) A. L. Hansen, M. D.  
 (Address) Appleton City, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD.

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

30M-3-19-38 I x(622)

RECEIVED FILED STATE OFFICE  
INDEX CARD RETURNED TO DISTRICT

DATE MAR 15 1964

RECEIVED District Health Officer No. 1, 7, 3-25-  
District File Number 3-4-470  
Date Filed 3-14-64

**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 Oscar Ekhoff  
Licensed Embalmer No. 3942  
P. O. Address Appleton City, WI

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7965-

Registration District No. 761

Primary Registration District No. 4456

Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Appleton city  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether  
In this community. years, months or days)

3. (a) PRINT FULL NAME Lucy E. Maxwell

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 47 Months 8 Days 2 If less than one day hr. min.

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

10. Usual occupation.

11. Industry or business.

MOTHER FATHER { 12. Name. 13. Birthplace. (City, town, or county) (State or foreign country) 14. Maiden name. (City, town, or county) (State or foreign country) 15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant. (b) Address.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year) (c) Place: burial or cremation.

18. (a) Signature of funeral director. (b) Address.

19. (a) Feb 1 1940 (Date received local registrar) (b) Oliver Abney (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

(c) City or town Appleton City  
(If outside city or town limits, write "RURAL")

(d) Street No. 105 - East 2<sup>nd</sup> St.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. years.

20. DATE OF DEATH: Month 1 day 30 year hour minute M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death. Duration

Due to.

Due to.

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations. Of autopsy.

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? While at work? (Specify type of place) (e) Means of injury.

23. Signature G. L. Hanson (M. D. or other) Address Appleton City Mo Date signed

