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MAY 15 1940
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13463

State File No.

3665

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No.

1. PLACE OF DEATH:

(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:
512 N. Sarah St.
(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)

8. (a) PRINT FULL NAME Kate Maxey **200**

3. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John W. Maxey 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 29, 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 6 22 hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name John Mc Fall

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

14. Maiden name Don't know
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Gus Maxey

(b) Address 4155 Olive St.

17. (a) Burial (b) Date thereof 4/24/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Pickers Cemetery

18. (a) Signature of funeral director Weick Bros. Un. Co.

(b) Address 2201 S. Grand Bl.

19. (a) APR 23 1940
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") **19**
(d) Street No. 512 N. Sarah St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21
year 1940 hour 4 minute 50 A. M.

21. I hereby certify that I attended the deceased from Apr 20
1940, to Apr 20th, 1940;
that I last saw her alive on Apr 20th, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Myocarditis
Due to _____
Due to _____

Other conditions hypertension, arteriosclerosis, chronic nephritis
(include pregnancy within 3 months of death)
Major findings:
Of operations _____

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 Clyde S Kane (M. D. or other)
Address 4624 Newberry Date signed 4/23/40

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

MOTHER FATHER

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 *Nancy A. Stewart*

Licensed Embalmer No. 3722

P. O. Address 412 Duchouquette St.

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.