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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

22695

FILED JUL 15 1940

State File No. \_\_\_\_\_

Registration District No. 761

Primary Registration District No. 4456

Registrar's No. 19

1. PLACE OF DEATH:

(a) County St. Clair  
(b) City or town Appleton City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
105 East 6th Street  
(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 William Francis Maxwell

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

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

6. (b) Name of husband or wife CORDELIA MAXWELL 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased Nov. 17 1854  
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Merchant

11. Industry or business \_\_\_\_\_

12. Name MADISON MAXWELL

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

14. Maiden name UNKNOWN

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

16. (a) Informant Nellie M. Maxwell

(b) Address Appleton City, Missouri

17. (a) BURIAL (b) Date thereof 5 15 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appleton City

18. (a) Signature of funeral director OSCAR FECHOFF

(b) Address Appleton City, Mo.

19. (a) May 15 1940 (b) Chas. Abney  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Clair  
(c) City or town Appleton City, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 1940  
year 1940 hour 1 minute 4

21. I hereby certify that I attended the deceased from July 1 1935, 19  , to May 14 1940, 1940  
that I last saw him alive on May 14 1940, 19  ,  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Coma  
Chronic Myocarditis

Due to Chronic Nephritis

Due to \_\_\_\_\_

Other conditions Cystitis Hypertrophy of prostate  
(Include pregnancy within 3 months of death)

Major findings: Of operations 121

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? 835  
(Specify type of place) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature R. L. Hanson (M. D. or other) MD  
Address Appleton City Mo Date signed 5-15-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

