No. 2
1-10-39
17-39
X21492

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

AUG 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

24723

State File No.

Registration District No. 85 Primary Registration District No. 5127 Registrar's No. 764

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Maxwell Heights R.F.D. 3 (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural - Washington Maxwell Heights R.F.D. 3 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ? (Specify whether) Life

In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town Maxwell Heights R.F.D. 3 (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.

3. (a) PRINT FULL NAME Birdie C. Maxwell 240

3. (b) If veteran, name war No

3. (c) Social Security No. No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Logan Maxwell

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased 1 (Month) 24 (Day) 1830 (Year)

8. AGE: Years 60 Months 5 Days 22 If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business 0

FATHER
12. Name Thomas Squires
13. Birthplace Buchanan (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Georgia White
15. Birthplace Unknown (City, town, or county) Michigan (State or foreign country)

16. (a) Informant Logan Maxwell

(b) Address Maxwell Heights RFD 3 St Joseph

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/40 (Month) (Day) (Year)

(c) Place: burial or cremation Maxwell Cem.

18. (a) Signature of funeral director Heaton Bergle & Bowman

(b) Address 319 So. 10 St. Joseph Mo.

19. (a) July 17 1940 (Date received local registrar) (b) AJ Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 16 year 1940 hour 2:50 A.M. minute ____ M.

21. I hereby certify that I attended the deceased from 8/16, 1938, to 7/16, 1940 that I last saw her alive on July 14, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Leukemia - spleno-myelogenous	4 yrs.
Due to ?	
Due to 72 H	
Other conditions Pneumonia - bronchial (Include pregnancy within 3 months of death)	7 days

Major findings:
Of operations no operation
Of autopsy none

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? 85 (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature G. T. Bloomer (M. D. ~~or other~~) 1

Address 1218 N. 3d Date signed 7/17/40

(Licensed Embalmer's Statement on Reverse Side)

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~~ 7/16/40

....., Registered Apprentice No.....

working under my personal supervision.

Signed Wm E Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 So 10th St Joseph Mo

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

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