

FILED OCT 23 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32906

Registration District No. 714

Primary Registration District No. 5944

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Pulaski

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

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

(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pulaski

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

(d) Street No. Roxae
(If rural, give location)

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

3. (a) PRINT FULL NAME WALYE MAXEY

3. (b) If veteran, name war _____

3. (c) Social Security No. NONE

4. SEX M

5. Color or race White

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

6. (b) Name of husband or wife John Maxey

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Nov 4 1871
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5th year 1940 hour 8 minute 42 PM

21. I hereby certify that I attended the deceased from July 2 1940, to Sept 5 1940 that I last saw him alive on Sept 13 1940 and that death occurred on the date and hour stated above.

8. AGE: Years 68 Months 10 Days 1 in min.

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

Immediate cause of death Coronary Thrombosis 9-5-40

Due to Cardio-vascular Renal disease 3 yrs

Due to Arterial Sclerosis 10 yrs

10. Usual occupation Housewife

11. Industry or business _____

12. Name John D Black

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

14. Maiden name Louise

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

Other conditions 171
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: none

Of operations _____

Of autopsy not

Underline the cause to which death should be charged statistically.

16. (a) Informant Mont Mosey

(b) Address Bloodland, Mo

17. (a) Roxae (b) Date thereof 9-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Family Cemetery

18. (a) Signature of funeral director R B People

(b) Address Bloodland, Mo

19. (a) 9-10-40 (b) S S Rooney
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) not

(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? no (Specify type of place) _____

(e) Means of injury _____

23. Signature G. Mallett (M. D. or other) _____

Address Crocker Mo Date signed 9-8-40

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number 104 0970

Date Filed _____

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 _____

Licensed Embalmer No. 3198

P. O. Address Rehland Mo

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.