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3-40
7-39
X23159

NOV 13 1940 ³⁹⁹

Primary Registration District No. 1002

Registrar's No. 4108

1. PLACE OF DEATH: Jackson
 (a) County Kansas City
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St Lukes Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 days (Specify whether
 In this community 75 years years, months or days)

3. (a) PRINT FULL NAME Martha A. Maxwell
 3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex fe 5. Color or race wh 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife William A Maxwell 6. (c) Age of husband or wife if alive 76 years (Month) 76 (Day) 1871 (Year)

8. AGE: Years 69 Months 4 Days - If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

MOTHER FATHER
 12. Name John Maxwell
 13. Birthplace Tenn (City, town, or county) (State or foreign country)
 14. Maiden name Mary Burgess
 15. Birthplace Tenn (City, town, or county) (State or foreign country)

16. (a) Informant Miss Maxwell

(b) Address 612 West 70 tenac

17. (a) Burial (b) Date thereof Oct 78-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Episcopal Spring, Mo

18. (a) Signature of funeral director Benjamin Burdick

(b) Address 436 Mill Creek Pky

19. (a) 10/27/40 (b) M. M. Crowe (Date received legal registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Jackson
 (c) City or town Kansas City Mo (If outside city or town limits, write "RURAL")
 (d) Street No. 612 West 70 tenac (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 26th year 1940 hour 4 minute 55 A.M.

21. I hereby certify that I attended the deceased from October 23rd, 1940, to Oct 26, 1940, that I last saw her alive on Oct 25, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis Hypertension
 Due to 131
 Due to _____

Other conditions Hypostatic Pneumonia (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy chronic nephritis
 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 H. P. Boynton (M. D. or other) M. D.
 Address 1116 Professional Bldg Date signed 10-27-40

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

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.....

A.C. Bergman

Licensed Embalmer No. *2041*

P. O. Address: *Kan City, 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, fact should be so stated above.