N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED JAN 23 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41693

Registration District No. 2 Primary Registration District No. 2 1 Registrar's No.

1. PLACE OF DEATH:

(a) County Andrew

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

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

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew

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

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

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

3. (a) PRINT FULL NAME George W. Paxton

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Bertha Annie Paxton

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

7. Birth date of deceased Feb (Month) 25 (Day) 1855 (Year)

8. AGE: Years 85 Months 9 Days 16 If less than one day hr. min.

9. Birthplace Worth Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Joseph Paxton
13. Birthplace no record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Louisa Bowers
15. Birthplace no record (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. George Paxton

(b) Address Amazonia Mo

17. (a) B (Burial, cremation, or removal) (b) Date thereof 12-14-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Amazonia Mo

18. (a) Signature of funeral director E. R. Breck

(b) Address Savannah Mo

19. (a) 12-14-40 (Date received local registrar) (b) J. W. Holcomb (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 11 year 1940 hour 12 minute 35 P.M.

21. I hereby certify that I attended the deceased from occasionally for the [illegible] 19__; that I last saw him alive on Dec 9, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Parallysis (Ascending) & Senility	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature S. S. Bevis Mo. (M. D. or other)

Address Amazonia Mo. Date signed 12/19/40

(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~~.....

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

working under my personal supervision.

Signed E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Sacramento Ca

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.