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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

43768

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

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 2338

1. PLACE OF DEATH: St. Louis  
 (a) County Clayton  
 (b) City or town Clayton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Louis County Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 21 days  
 (Specify whether life)  
 In this community life  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County St. Louis  
 (c) City or town Overland  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 9730 Baltimore Ave  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

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

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec. day 11  
 year 1940 hour 12 minute :06 A. M.

4. Sex male 5. Color or race white  
 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from 11-20-40  
 \_\_\_\_\_, 19\_\_\_\_, to 12-11-40, 19\_\_\_\_;  
 that I last saw him alive on 12-11-40, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

7. Birth date of deceased Nov. 20 1940  
 (Month) (Day) (Year)

Immediate cause of death  
Pneumonia  
Malnutrition

8. AGE: Years Months Days If less than one day  
0 0 21 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
159

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

Other conditions (Include pregnancy within 3 months of death)  
 \_\_\_\_\_

10. Usual occupation nil  
 11. Industry or business \_\_\_\_\_  
 12. Name Walter Maxwell  
 13. Birthplace Unknown Mo.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Edith Jose  
 15. Birthplace Unknown Mo.  
 (City, town, or county) (State or foreign country)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

16. (a) Informant Walter Maxwell  
 (b) Address 9730 Baltimore Ave  
 17. (a) Burial (b) Date thereof 12/12/40  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Free Free Cem  
 18. (a) Signature of funeral director Baumman Bros  
 (b) Address 2504 Woodson St. Overland Mo.  
 19. (a) DEC 11 1940 (b) R Meyer M. D.  
 (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) \_\_\_\_\_  
 (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 James Bond M. D. (M. D. or other) \_\_\_\_\_  
 Address St Louis Co. Hosp. Date signed 12/11/40

Duration  
7 med.  
2 1/2 day  
 PHYSICIAN  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

**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.....

*Oscar F. Mueller*

Licensed Embalmer No. 3039

P. O. Address Overland Park

**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.**