

Registration District No. 464

Primary Registration District No. 5627

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Rural Sniabar Twp. 3
(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)
In this community 40 Yrs.
years, months or days

3. (a) PRINT FULL NAME Samuel Louis Maxwell

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex M O 5. Color or race W 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased April 25 1860
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>11</u>	<u>14</u>	_____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Albert Maxwell

13. Birthplace North Carol
(City, town, or county) (State or foreign country)

14. Maiden name Dolly Harman

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

16. (a) Informant A. P. Maxwell

(b) Address Odessa, Mo.

17. (a) Burial (b) Date thereof Apr. 12, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woods Chapel Johnson

18. (a) Signature of funeral director Ch. Homan

(b) Address Odessa, Mo.

19. (a) 4-10-41 (b) Mrs. E. M. Goodwin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 33
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 2 miles south of Odessa
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9th
year 1941 hour 5 minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____ 1939

that I last saw him alive on Sept 26 and that death occurred on the date and hour stated above.

Immediate cause of death Failure of

the heart - Coronary Artery Disease -

Due to Chronic Coronary Artery Disease -

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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 R. S. Shaaley (M. D. or other) _____
Address Odessa, Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 8,
District File Number
Date filed 5-5-41

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 Irving L. Heuman
Licensed Embalmer No. 7541
P. O. Address Alma, 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.