

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41212
5028
Registrar's No. _____

FILED DEC 22 1943
Registration District No. 199

Primary Registration District No. 1002

PRINTED AT THE MISSOURI STATE PRINTING PLANT, ST. LOUIS, MO. 1943. U.S. GOVERNMENT PRINTING OFFICE: 1933. O-488. THIS IS A PERMANENT RECORD.

1. PLACE OF DEATH:
(a) County Jackson,
(b) City or town Kansas City,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7304 Walnut Street, /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no. (Specify whether)
In this community 25 years, (Specify whether)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson, 48
(c) City or town Kansas City, 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 7304 Walnut Street,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country x 1

3. (a) PRINT FULL NAME Millard Adelbert Paxson,
(b) If veteran, name war no. (c) Social Security No. 513-14-1892

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November day 26th
year 1943 hour 2:35 minute P. M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Mrs. Linnie Paxson (c) Age of husband or wife if alive 39 years
7. Birth date of deceased: June 12 1903
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-18 1939 to Nov 26 1943
that I last saw him alive on Nov 23 1943
and that death occurred on the date and hour stated above.

AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>5</u>	<u>14</u>	hr. min.

Immediate cause of death Chronic Alcoholism 3-4 years
Duration 3-4 years

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

Due to 77d
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation Laboratory Technician

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business x
12. Name Charles A. Paxson,
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Boigart Sweet
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____

16. (a) Informant Mrs. Linnie Paxson,
(b) Address 7304 Walnut St., Kansas City, Mo.
17. (a) Burial (b) Date thereof 11-29-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery

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? _____

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, Kansas City, Mo.
19. (a) 11-29-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

23. Signature E. W. H. Treassey (M. D. or other) _____
Address 1032 P. W. Bedy, KC signed 11-27-43

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Dr. H. H. Theisen, Prof. Bldg.

2 P.M.

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

John H. Hurley

Licensed Embalmer No. *40501*

P. O. Address

Kansas 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.