

FILED MAY 24 1944

State File No. _____

Registration District No. 72

Primary Registration District No. 1008

Registrar's No. 25-3

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community 35 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1521 Prospect Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Minnie May Maxfield

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Frank Maxfield 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased November 13 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 5 9 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Maxfield

(b) Address 2903 Penn St., St. Joseph, Mo.

17. (a) Burial (b) Date thereof 4/24/1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1302 Faraon St., St. Joseph, Mo.

19. (a) W. J. W. (b) W. J. W.
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22nd.
year 1944 hour 8:40 minute A. M.

21. I hereby certify that I attended the deceased from Apr 19 1944 to Apr 21 1944
that I last saw him er alive on Apr 21 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 4/19/44.

Due to arterio sk. gl.

Due to neph. chr.

Other conditions Diab. mel. Met. ar. stases
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy None

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 Frank Maxfield (M. D. or other) _____
Address 675 Spruce Date signed 4/22/44

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 *Albert E. Harrington*
Licensed Embalmer No. 3258 Missouri
P. O. Address St. Joseph, Missouri

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.