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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 24 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23810

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2909

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:
945 West 42nd. Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

In this community One week
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Allen 999

(c) City or town Moran 140
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Charles F. Maxwell

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs Bertha Maxwell 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Nov. 3rd 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>8</u>	<u>9</u>	hr. min.

9. Birthplace Vernon County Mo. D
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER { 12. Name George Maxwell

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

14. Maiden name Mollie Maxwell

15. Birthplace Lynn County Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Charles C. Maxwell

(b) Address 945 West 42nd, Kansas City, Mo.

17. (a) Removal (b) Date thereof 7-12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moran, Kansas

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Mo.

19. (a) 7-13-44 (b) M. E. Brown
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 6 44 to July 12 19 44
that I last saw him alive on July 6 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Prostatic Gercinoma

Due to _____

Due to _____ 51

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 Dr. E. H. Bird (M. D. or other) D. O.

Address 1313 Westport Rd Date signed 7/12/44

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

839

*Dr. Reed
13/13 Westport Rd.*

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 Walter H. Erwin
Licensed Embalmer No. 4352
P. O. Address Hanna 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.