V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36829

Registration District No. FILED NOV 20 1944 Primary Registration District No. 1602 Registrar's No. 4473

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: Research Hospt. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Weeks (Specify whether
In this community 3 weeks. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lafayette 54
(c) City or town Odessa 4
(If outside city or town limits, write "RURAL") 0
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Martha M. Maxwell
3. (b) If veteran, name war no
3. (c) Social Security No. 500-10-5425
4. Sex Fe 1
5. Color or race W
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept. (Month) 7. (Day) 1883 (Year)

8. AGE: Years 61 Months 1 Days 26 If less than one day hr. min.

9. Birthplace Odessa, (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation Bookkeeper
11. Industry or business
FATHER
12. Name Lee Maxwell
13. Birthplace (City, town, or county) unknown (State or foreign country) 9
MOTHER
14. Maiden name Sarah A. Edland
15. Birthplace (City, town, or county) Ill. (State or foreign country) 1
16. (a) Informant ARthur Maxwell,
(b) Address Lexington, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov, 3, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Odessa, Mo.
18. (a) Signature of funeral director L. C. Husman
(b) Address Odessa, Mo.
19. (a) 11-6-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 3 year 1944 hour 7 minute 45 A. M.
21. I hereby certify that I attended the deceased from Oct 11, 1944 to Nov 3, 1944 that I last saw her alive on Nov 2, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Fibrinous Pericarditis — Duration 3 wks
Due to Etiology undetermined
Due to Virus?
Other conditions (Include pregnancy within 3 months of death) 90 b
Major findings: Of operations None
Of autopsy Same as above —

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 Carl R. Ferris (M. D. or other)
Address 93 X Aiggle Bldg Kansas City, Mo Date signed Nov 3, 1944

(Licensed Embalmer's Statement on Reverse Side)

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 Joing L. Heisman

Licensed Embalmer No. 2541

P.O. Address Odessa 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.