

20552

5. No. 2  
-11-10-39  
-5-17-39  
-I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JUL 13 1945 STANDARD CERTIFICATE OF DEATH**

MISSOURI STATE BOARD OF HEALTH

State File No. \_\_\_\_\_

Registration District No. 251

Primary Registration District No. 3045

Registrar's No. 99

4  
1  
2

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

**1. PLACE OF DEATH:**

(a) County Madison

(b) City or town Marionville Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Francis Hospital  
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days)

In this community 9 days

**3. (a) PRINT FULL NAME** Charles Gibson Maxwell

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced 2 divorced

6. (b) Name of husband or wife Cynthia Ann Maxwell 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

8. AGE: Years <u>84</u>	Months <u>8</u>	Days <u>8</u>	If less than one day hr. _____ min. _____
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9. Birthplace Page Co Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Robert Max well

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

14. Maiden name Chaitha Judd

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

16. (a) Informant Merritt P. Boy

(b) Address Burlington Junction

17. (a) Removed (b) Date thereof 6-15-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shearer Cemetery

18. (a) Signature of funeral director Leah D. Walker

(b) Address Charanda Joux

19. (a) 6-15-45 (b) Archie Barber  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Wabaway

(c) City or town Burlington Junction 74  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 15 Friday -  
year 1945 hour \_\_\_\_\_ minute 2 P. M.

21. I hereby certify that I attended the deceased from June 6, 1945, to June 15, 1945,  
that I last saw him alive on June 15, 1945,  
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture - 1st rib

Due to <u>Simple fracture of surgical neck of left femur</u>	Duration _____
Due to _____	_____

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

**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 H. M. Nellis (M. D. or other) \_\_\_\_\_  
Address Maryville - Mo Date signed 6-15-45

(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 Loren

Damon De Long

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

RECEIVED

District Health Officer No. 11,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

Signed Zeshe D Walker

Licensed Embalmer No. 2156 09

P. O. Address \_\_\_\_\_

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
Registrar's No. 948

Registration District No. 251 Primary Registration District No. 3048

1. PLACE OF DEATH:

(a) County Madison  
(b) City or town Madisonville  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

Charles G. Maxwell

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Oct 7  
(Month) (Day) (Year)

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Iowa

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

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) accident

(b) Date of occurrence June 6 - 1946

(c) Where did injury occur Madisonville, Mad. Co.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home

While at work? Retired (Specify type of place) (e) Means of injury fall

23. Signature H. M. Hallis (M. D. or other) M.D.

Address Madisonville Mo Date signed 7-16-46

WRIT MAINLY - U FADING BLACK INK - MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

20952