

No. 2  
1-5-42  
5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

**FILED NOV 15 1945 STANDARD CERTIFICATE OF DEATH**

34815

State File No. ....

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 18

**1. PLACE OF DEATH:**

(a) County Scott  
(b) City or town Sikeston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Sikeston General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 Days  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Scott  
(c) City or town Sikeston  
(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 .....

**3. (a) PRINT FULL NAME**

Brenda Kay Maxwell

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 2  
year 1945 hour 7:30 minute ..... M.

21. I hereby certify that I attended the deceased from Sept 24 to Oct 2, 1945  
that I last saw her alive on Oct 2, 1945  
and that death occurred on the date and hour stated above.

4. Sex FEMALE

5. Color or race W

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased Sept 24 - 1945  
(Month) (Day) (Year)

Immediate cause of death Seters Gravis  
Due to Prematurity

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

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

10. Usual occupation Child

11. Industry or business .....

Due to.....  
Other conditions (Include pregnancy within 3 months of death) .....

MOTHER FATHER

12. Name H. J. Maxwell

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

14. Maiden name Frankie Williams

15. Birthplace Mozel Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant H. J. Maxwell

(b) Address Phuwaner, Miss

17. (a) Burial (b) Date thereof Oct 3 - 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston

18. (a) Signature of funeral director Richard Lind

(b) Address Fun. Mod. Inc.

19. (a) 10-26-45 (b) Mrs. P. F. Henry  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations.....  
Of autopsy..... 159

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 D. J. Allen (M. D. or other)  
Address New Madrid Mo. Date signed 10/10/45

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

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

RECEIVED

District Health Office No. 2

District File Number 1145-3195

Date Filed 11-3-45

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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 Not Embalmed.....

Licensed Embalmer No.....

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, fact should be so stated above.**