

U. S. No. 2
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REV. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U. S. STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42629**

Registration District No. **336** Primary Registration District No. **6125** Registrar's No. _____

1. PLACE OF DEATH
(a) County **Shannon**
(b) City or town **Summersville Mo. R. 4**
(If outside city or town limits, write "RURAL" and name of town or place)
(c) Name of hospital or institution: **Casto Sup**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **14 yrs.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Frank Warren Maxfield**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M O** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Minnie Maxfield**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **May 28 1867**
(Month) (Day) (Year)

8. AGE: Years **78** Months **6** Days **16** If less than one day _____ hr. _____ min.

9. Birthplace **Benton Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **mercantile**

11. Industry or business _____

MOTHER FATHER {
12. Name **James Maxfield**
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 **Everett Maxfield**
(b) Address **R. F. 4 Summersville Mo**

17. (a) **Removal** (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Joseph Mo**

18. (a) Signature of funeral director **Rayford V. Elliott**
(b) Address **Carroll Mo**

19. (a) **12-19-45** (b) **Make Roeder**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED
(a) State **Mo** (b) County **Shannon 101**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **near Summersville Mo**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **14**
year **1945** hour **45** minute **9** A. M.
21. I hereby certify that I attended the deceased from **Dec 1 1945** to **Dec 7 1945**
that I last saw him alive on **Dec 7 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **apoplexy**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings:
1. Of operations _____
Of autopsy _____
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 **Dr. Sumner Knight** (M. D. or other)
Address **Summersville** Date signed **Dec 15**

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

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Case No. 2

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

Gaylord Elliott

Licensed Embalmer No. *2252*

P. O. Address. *Carroll, Md*

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.