

FILED NOV 6 1946  
Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

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

Registrar's No. 842

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

1. PLACE OF DEATH:  
 (a) County GREENE  
 (b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Johns  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. 3 days  
(Specify whether years, months or days)  
 In this community \_\_\_\_\_

3. (a) PRINT FULL NAME John William Maxwell  
 3. (b) If veteran, name war World War I  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male  
 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Ona  
 6. (c) Age of husband or wife if alive 46 years  
 7. Birth date of deceased: Oct. 28 1898  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>11</u>	<u>20</u>	<u>20</u> min.

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

10. Usual occupation Machenist

11. Industry or business Machenist

12. Name W.M. Maxwell

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

14. Maiden name Bessie Denberry Ga.

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

16. (a) Informant Mrs. Ona Maxwell

(b) Address 808 W. Chase

17. (a) Burial  
(Burial, cremation, or removal) (b) Date thereof 10-20-46  
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director W. Klingner & Co.

(b) Address Springfield Mo.

19. (a) 10-20-46 (b) W. S. Handley MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 Missouri Greene 39  
 (a) State (b) County  
 (c) City or town Springfield 2  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 808 West Chase 6  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18  
 year 1946 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from March 2nd 1942 to Oct 18 1946  
 that I last saw him alive on Oct 18 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus 10 yrs  
 Duration \_\_\_\_\_

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

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

Other conditions Cardiac  
(Include pregnancy within 3 months of death)  
Decompensation

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

Of autopsy W

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? \_\_\_\_\_

White at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature Robert J. ... (M. D. or other) MD  
 Address Springfield Mo Date signed Oct 19 1946

MAR 25 1947  
JAN 20 1947

DEC 17 1946

FEB 24 1953

NOV 6 1946

NOV 12 1946

**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 *Ogl. Stone Jr.*

Licensed Embalmer No. *4176*

P. O. Address *Springfield*

**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.**

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