S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 4 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32795

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9039

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: De Paul Hospital 0
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 5247 Wabada Ave. 9
(If rural, give location)

6 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ANNA J. MAXWELL

3. (b) If veteran, name war

3. (c) Social Security No. #488-01-1943

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife John A. Maxwell

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

7. Birth date of deceased October 1st 1891
(Month) (Day) (Year)

8. AGE: Years 55 Months 11 Days 26 If less than one day hr. min.

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Saleslady

11. Industry or business Famour-Barr Company

FATHER
12. Name John Colvin
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Catherine O'Brien
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. John A. Maxwell-Husband,
(b) Address 5247 Wabada Avenue,

17. (a) burial (b) Date thereof 9-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Calvary Cemetery

18. (a) Signature of funeral director Sullivan Brothers,
(b) Address 2849 North Euclid Avenue,

19. (a) SEP 29 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27th
year 1947 hour 12:05 P.M. minute M.

21. I hereby certify that I attended the deceased from May 24, 1947, to Sept 27, 1947
that I last saw her alive on 9/27, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Carcinoma of Cervix Uteri

Due to with generalized metastases

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Biopsy revealed Carcinoma

Of autopsy

PHYSICIAN
Underline the cause of 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 0

23. Signature George A. Carroll (M. D. or other)

Address 607 N. Grand Date signed 9/27/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Dr. Geo. Carroll
&
Dr. Francis Medler

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 Robert L Brinkman

Licensed Embalmer No. 3553

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.