

No. 300  
-10-47  
-17-39  
PI 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED MAY 15 1948  
Registration District No. 3887

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 15014  
Registrar's No. 1203

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Jennings  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Elms Convelescing Home 4  
(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 JOHN F. MAXWELL  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Hannah Maxwell  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 26, 1857  
(Month) (Day) (Year)

8. AGE: Years 90 Months 10 Days 13  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Osage County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

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

MOTHER FATHER  
12. Name Campbell Maxwell  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Fincher  
15. Birthplace Tennessee  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. N. A. Moses  
(b) Address 5363 Arlington Avenue

17. (a) Burial (b) Date thereof May 10, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Chamois Missouri

18. (a) Signature of funeral director Shepard Funeral Home  
1167 Hamilton Avenue  
(b) Address

19. (a) 5-10-48 (b) Shepard  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Osage 76  
(c) City or town Chamois 5  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No) 1  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9, 1948  
year 6 hour 30 minute P M.

21. I hereby certify that I attended the deceased from January 1, 1948 to May 9, 1948  
that I last saw him alive on May 7, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Autoselectic Cardiac disease, Cerebral thrombosis  
Duration 5 mos

Due to \_\_\_\_\_  
Due to 93d

Other conditions deaf degenerative arthritis, Senile dementia  
(Include respiratory within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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)  
(b) Means of injury \_\_\_\_\_

23. Signature Lewis Littman (M. D. or other) MD  
Address 9231 Clayton Rd Date signed 5/10/48

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

**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 *Gustav W. Dietrich*  
Licensed Embalmer No. *4329*  
P. O. Address *St Louis, Mo*

**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.**