

FILED JUL 19 1948

Registration District No. 143

Primary Registration District No. 4232

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Howell
 (b) City or town Willow Springs
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Horton Hotel 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 1 Month
 years, months or days)

3. (a) PRINT FULL NAME George W. MAXWELL

3. (b) If veteran, name war _____ 3. (c) Social Security No. 536-20-5633

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased _____ 1874
 (Month) (Day) (Year)

8. AGE: Years 74 Months _____ Days _____ If less than one day
 hr. _____ min. _____

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

10. Usual occupation Debiting

11. Industry or business _____

12. Name David Maxwell

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

14. Maiden name Margaret Maxwell

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

16. (a) Informant Ray E. Olds, Jr.

(b) Address Willow Springs, Mo.

17. (a) Burial (b) Date thereof 6/30/48.
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Willow Spgs. City Cemetery

18. (a) Signature of funeral director Burns Funeral Home,

(b) Address Willow Springs, Missouri

19. (a) 7/3/48 (b) Marshall P. ...
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Washington (b) County Spokane
 (c) City or town Spokane
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 29
 year 48 hour 1:04 minute 9 M.

21. I hereby certify that I attended the deceased from
6-17- 1948 to 6-27- 1948
 that I last saw him alive on 6-26- 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 42 hrs.

Due to arteriosclerosis

Due to _____

Other conditions Chr. Myocarditis 1 yr.
 (Include pregnancy within 3 months of death)

Major findings: MI PHYSICIAN _____

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 C.F. Callinan (M. D. or other) _____

Address Willow Springs, Mo. Date signed 7-2-48

RECEIVED 7-12-48
District Health Officer No. 5,
District File Number 748452
Date Filed 7-13-48

AUG 6 1948

VS AUG 10 1948

COPIES TO BE DESTROYED

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.

not embalmed

Signed.....

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.

Registration District No. 143

Primary Registration District No. 4232

1. PLACE OF DEATH:
(a) County Howell
(b) City or town Willow Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME George W. Maxwell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 74 Months _____ Days _____ (less than one day) _____ hr. _____ min.

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

10. Usual occupation Night Detective in Hotel in Washington

11. Industry or business _____
MOTHER FATHER { 12. Name _____
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 _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH Month Aug Year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

Major findings:
Of operations _____
Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

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

1948-20

S-22997