

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

22403

State File No. ....

FILED JUN 27 1949

No. 300

10-48

BIRTH NO. 39517-49 REG. DIST. NO. 374 PRIMARY REG. DIST. NO. 6273 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <b>Worth</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Worth</b> c. CITY (If outside corporate limits, write RURAL and give township) <b>Rural-Fletcher Township</b> d. STREET ADDRESS (If rural, give location)		
b. CITY (If outside corporate limits, write RURAL and give township) <b>Rural-Fletcher Township</b>			c. CITY (If outside corporate limits, write RURAL and give township) <b>Rural-Fletcher Township</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS		

3. NAME OF DECEASED (Type or Print) <b>Infant Maxwell</b>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) <b>6</b> (Day) <b>10</b> (Year) <b>1949</b>
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>6 10 1949</b>	9. AGE (In years last birthday) <b>15</b> IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Grant City, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Maxwell</b>	13b. MOTHER'S MAIDEN NAME <b>Sadie Sanders Maxwell</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>John Maxwell</b> ADDRESS <b>Grant City, Mo.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Medicinal Certification: Hematuria severe and on left kidney</b>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 6-10, 1949, to 6-10, 1949, that I last saw the deceased alive on 6-10, 1949, and that death occurred at 4 P.M., from the causes and on the date stated above.

23a. SIGNATURE <b>Charles F. Hellerman</b> (Degree or title) <b>DO 2</b>	23b. ADDRESS <b>Grant City, Mo.</b>	23c. DATE SIGNED <b>6-13-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>6 11 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Grant City Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Grant City, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>June 14 1949</b>	REGISTRAR'S SIGNATURE <b>John E. Dawson</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Arch C. Duffell</b> ADDRESS <b>Grant City, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

13  
0  
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 self

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Arch C. Dunfee*

Licensed Embalmer No. 3252

P. O. Address Grant city 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.