

FILED MAY 10 1950

THE DIVISION OF HEALTH OF MONTANA  
STANDARD CERTIFICATE OF DEATH

State File No. 14786

318

1003

Registrar's No. 4447

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Montana</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Fort Shaw</u>		<u>8250</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>8</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William Archer</u> b. (Middle) _____ c. (Last) <u>Maxwell</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 3 1950</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>		8. DATE OF BIRTH <u>Feb. 11-1947</u>	
9. AGE (In years if under 1 year last birthday) Months Days <u>3 3</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Great Falls, Mont.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>		13a. FATHER'S NAME <u>Wallace W. Maxwell</u>		13b. MOTHER'S MAIDEN NAME <u>Jeanette Edy</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Jeanette Maxwell Fort Shaw Montana</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pectus excavatum</u> ANTECEDENT CAUSES <u>atelectasis of right lower lobe of lung</u> Morbidity 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.					INTERVAL BETWEEN ONSET AND DEATH <u>3 1/4 yrs.</u> <u>1 day.</u>
19a. DATE OF OPERATION <u>5-2-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Pectus excavatum</u>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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)		<u>749X</u>	
21d. TIME OF INJURY (Month) (Day) (Year); (Hour) m. <u>5-3-50</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-1-1950</u> to <u>5-3-1950</u> that I last saw the deceased alive on <u>5-13-1950</u> and that death occurred at <u>8pm.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm. G. Klingbeorn</u>				23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>5-3-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City</u>		24d. LOCATION (City, town, or county) (State) <u>Great Falls, Montana</u>		
DATE REC'D BY LOCAL REG. <u>MAY 3 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington</u>			

(Licensed Embalmer's Statement on Reverse Side)

Elton  
WRITE PLAINLY—USING 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 Me

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed *E. J. Penick*

Licensed Embalmer No. 4273

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.