

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2792

State File No. \_\_\_\_\_

FILED JAN 26 1951

400

BIRTH NO. <u>4773-51</u>		REG. DIST. NO. <u>318</u>	PRIMARY REG. DIST. NO. <u>1003</u>	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Place deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>Life</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2129</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Marys Infirmary.</u>		12. STREET ADDRESS (If rural, give location) <u>5165 Lindell Blvd.</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Michel</u>		b. (Middle) <u>Lee</u>	c. (Last) <u>Maxwell</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan, 13, 1951</u>
5. SEX <u>Male</u> <u>2</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan, 12, 1951</u>	9. AGE (in years last birthday) IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u> <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Ernest Maxwell</u>		13b. MOTHER'S MAIDEN NAME <u>Virgina Mathew</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Ernest Maxwell 5165 Lindell Blvd.</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Oxygen deficiency</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>to truncus arteriosus</u> DUE TO (c) <u>Complete atelectasis of left lung.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input 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) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <u>762.0</u>		
22. I hereby certify that I attended the deceased from <u>1-12-</u> , 19 <u>51</u> , to <u>1-13-</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1-13-</u> , 19 <u>51</u> , and that death occurred at <u>Loop</u> m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>James W. Smith MD</u>		23b. ADDRESS <u>1023 No. Grand Blvd</u>	23c. DATE SIGNED <u>1-15-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan, 15, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE RECEIVED BY LOCAL HEALTH DEPT. <u>JAN 15 1951</u>	REGISTRAR'S SIGNATURE <u>J. B. Karater</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wright Funeral Home</u> ADDRESS <u>2000 Easton.</u>		

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

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**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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed..... No Embalming.....

Signed.....  
Student Embalmer

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.